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ABSTRACT

The task group process and its operating rules are explained in an initial section of this report. Summaries and updates are then presented of project products and activities: a pilot community-based class program (an intensive educational and therapeutic environment for emotionally disturbed adolescents); a case management system (in which the merits of therapists or others as case managers are reviewed); the individual therapeutic and educational program; committee work on the defining of severe emotional disturbances and implications for service delivery; interviews with mental health professionals, support staff, and teachers of severely emotionally disturbed students; results of a vocational survey; inservice training and information dissemination activities; parent support groups; and development of an information and referral guide. (CL)]

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Pasco/Pinellas Multiagency Network for Severely Emotionally Disturbed Students

Report to the State of Florida SED Advisory Board

June 26, 1984

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REPORT TO THE STATE OF FLORIDA
SED ADVISORY BOARD

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PASCO/PINELLAS SED NETWORK

CHRONOLOGY OF

SIGNIFICANT EVENTS
January-June, 1984

January 2, 1984 - Video tape activity data collection instruments finalized.

January 5, 1984 - SED Network staff meeting.

January 9, 1984 - Sanders School (SED Center) establishes affective/therapeutic groups; Maureen Gale acts as a group facilitator.

January 9, 1984 - Rough draft of Information and Referral Guide completed.

January 10, 1984 - ITEP Implementation Training Workshop design completed.

January 10, 1984 - Safety Harbor Exceptional Student Center (SED Center) implements parent training/education groups (funds for trainers provided by the SED Network).

January 11, 1984 - Training for teachers involved in video tape activity completed.

January 12, 1984 - Project Manager attended Regional Meeting/Programs for Emotionally Handicapped Students, Tampa.

January 12, 1984 - Juvenile Welfare Board approved funding for Community-Based Classroom Program (alternative program for SED delinquents designed cooperatively by Pinellas County Schools, Mental Health Services of South Pinellas and the SED Network.

January 13, 1984 - SED Network staff meeting.

January 16, 1984 - Data collection for video tape activity begins.

January 17, 1984 - SED Network Advisory Committee meeting.

January 17, 1984 - ITEP goal development sub-committee meeting.

January 20, 1984 - ITEP Implementation Training for Pasco County Adolescent Day Treatment Programs.

January 23, 1984 - ITEP Implementation Training for Pinellas County Adolescent Day Treatment Programs.

January 24, 1984 - Pinellas County Schools presents Legislative Program to all administrators; services to SED children were on the 'plank' of total package.

January 24-25, 1984 - SED State Advisory Board Meeting in Cedar Key.

January 26, 1984 - SED Service Network Regional Meeting, Tampa.

January 26-27, 1984 - Florida Institute of Mental Health, Children's Mental Health Workshop: Policies and Programs for the Emotionally Disturbed Delinquent.

January 27, 1984 - Pinellas County School's SED Task Force meets to discuss staff development needs of teachers and support personnel; SED Network staff provide input from local needs assessments.

January 30, 1984 - Meeting with Horizon Hospital staff to discuss private hospital representation on SED Network Advisory Committee.

January 30, 1984 - SED Network personnel participate in ACT Training; Carol Makin moves to advanced status.

January 31, 1984 - Case Management System Development Committee meeting.

February 1, 1984 - SED Network staff meets with Pinellas County School personnel to discuss program/teacher needs when working with violent, aggressive youth.

February 1, 1984 - All video tape activity training completed (four separate sessions for participating teachers).

February 1, 1984 - SED Network contacted by Governor's Committee on Advisory for Persons with Disabilities to discuss a case decided by the District V Case Review Committee.

February 2, 1984 - ITEP Training delivered to Community-Based Classroom Program staff.

February 3, 1984 - SED Network staff meeting.

February 7, 1984 - Meeting with Judge Page to discuss Juvenile Court representation and support of the SED Network.

February 8, 1984 - Teacher support planning committee holds final meeting.

February 8, 1984 - Meeting with HRS District V District Administrator to develop plans for juvenile justice and vocational rehabilitation linkages.

February 9, 1984 - Network staff assist in developing/implementing the behavior management program at Safety Harbor Exceptional Student Center (SED Center).

February 10, 1984 - SED Network staff presents an overview of the Community-Based Classroom Program to Department of Education for Exceptional Students (DEES) staff of Pinellas County.

February 10, 1984 - Presented rationale for funding one Network staff position to Pinellas County Schools Administration.

February 13, 1984 - Meet with Advisory Committee sub-group to outline legislative action planning to facilitate LBR for children.

February 15, 1984 - Juvenile Welfare Board's Legislative Workshop.

February 16, 1984 - SED Network staff meeting.

February 16, 1984 - Case Management System Development Committee meeting.

February 18, 1984 - Meet the Leaders: Regional Conference for EH/SED Children/ Youth (partially funded by the SED Network, Juvenile Welfare Board, FDLRS and Hillsborough County Schools).

February 20, 1984 - SED Network Evaluation Consortium meeting.

February 21, 1984 - SED Network Advisory Committee meeting.

February 23, 1984 - Network staff meet with Medfield Center Staff and tour adolescent center.

February 23-24, 1984 - FMHI Children's Mental Health Workshop "Prevention, Early Childhood and Early Identification.

February 24, 1984 - Pinellas County School's SED Task Force Meeting, Topic: SED Referral and Placement Procedures.

February 27, 1984 - Meeting with Operation PAR staff to investigate interface between SED programs and substance abuse programs in Pinellas County.

February 28, 1984 - SED Network staff member attends FCCMH Conference on the Mentally Ill Violent Client, Tallahassee.

February 28, 1984 - Meet with All Children's Hospital Administrator to begin linkage of hospital services for the SED population.

February 28, 1984 - Case Management System Development Committee (Steering Committee) formalize job descriptions for case managers.

February 29, 1984 - Problematic behavior of students at the Community-Based Classroom Program initates additional planning meeting between educators and mental health professionals.

February 29, 1984 - SED Network staff participate in the HRS/School Communication Committee in an ongoing basis.

February, 1984 - Carol Makin participates as master teacher in the Pinellas County School's Beginning Teacher Program.

March 1, 1984 - SED Network staff present Multiagency Network concept at the Council for Exceptional Children Leadership Conference, Pensacola.

March 2, 1984 - SED Network staff met with Sanders School personnel to discuss socially maladjusted/severely emotionally disturbed definition dilemma.

March 5, 1984 - Development of two new SED programs increases case load of education and mental health supervisors of those programs due to increased case load.

March 6, 1984 - SED Network staff met with Medfield Center staff to foster linkages between hospital and school based SED programs.

March 7, 1984 - Plans formalized for CYF to fund the eastside adolescent day treatment program in Pasco County (Mental Health Specialist I position funded by the Network grant will be funded by CYF due to savings realized by moving the program to a school campus site).

March 8, 1984 - One of many ongoing site visits to Pasco and Pinellas adolescent day treatment programs to monitor/assist in ITEP implementation.

March 9, 1984 - Met with Eckerd Foundation staff to determine replacement for an outgoing Advisory Committee member.

March 9, 1984 - Susan Yelton, CYF requested that SED Network staff assist in the development of a needs assessment instrument to determine residential needs for the SED population.

March 12, 1984 - SED Network staff participate in FDLRS Advisory Committee.

March 13, 1984 - Initial contact with direct service providers at the Juvenile Detention Center; initation of mental health, education and juvenile justice linkages.

March 13, 1984 - SED Network staff met with all Vocational Rehabilitation counselors in HRS District V to continue exploring career/vocational options for SED students.

March 15, 1984 - SED Network staff visited residental treatment home for substance abusing adolescents (Funded by Operation PAR).

March 15, 1984 - SED Network staff continue participation in the Juvenile Welfare Board's Youth Services Advisory Committee - Mental Health/Substance Abuse Committee.

March 15, 1984 - SED Network staff submitted a "Concept Paper" to the Juvenile Welfare Board that requested local funding for the Network project for 1985.

March 19, 1984 - SED Network Evaluation Consortium meeting.

March 20, 1984 - SED Network staff begin to investigate summer and after school recreation programs for SED students; met with the Supervisor of Special Population from the St. Petersburg Recreation Department.

March 23, 1984 - Follow-up meeting regarding socially maladjusted/severely emotionally disturbed issue; participants desire to separate the two groups to assist in delaying teacher burnout.

March 23, 1984 - Pinellas County School's SED Task Force Meeting; topic: SED definition.

March 22-23, 1984 - FMHI Children's Mental Health workshop, " Family Based Interventions.

March 26, 1984 - Case Management System Development Steering Committee meeting.

March 27, 1984 - SED Network staff met with Bay Area Hospital Council staff to enlist their support of involvement of local psychiatric hospitals in the SED Network.

March 28, 1984 - SED Network staff met with FMHI staff to discuss FACTS data collection project; potential implementation of data collection for non-residential population in HRS District V.

March 29, 1984 - ITEP Academic goals and objectives sub-committee meeting.

March 29, 1984 - Pinellas County Schools administrators and HRS intake supervisors formalize policy for filing charges (when needed) against violent, assaultive SED youths in school based programs.

March 29, 1984 - First of a series of individual meetings to finalize behavioral affective goals and objectives for ITEP (met with key mental health and education personnel).

March 29, 1984 - Case Management system proposal is finalized by Steering Committee.

March 30, 1984 - SED Network staff meeting.

March 30, 1984 - SED Network staff set up a meeting to involve several community agencies in the Community-Based Classroom Program.

April 2, 1984 - Information and Referral Guide ready for Advisory Committee review.

April 2, 1984 - ITEP Academic goals and objectives committee meeting.

April 3, 1984 - SED Network staff complete socially maladjusted/severely emotionally disturbed position paper.

April 4, 1984 - SED Network staff met with the Supervisor of Alternative Education Programs to discuss SED/Alternative Education (juvenile commitment programs) interface.

April 4, 1984 - Disruptive behavior of students at Community-Based Classroom Program disturbs the Director of Enoch Davis Center (CBCP) site. Began search for an alternative CBCP site.

April 9, 1984 - Data collection completed for video tape activity.

April 10, 1984 - SED Network Advisory Committee meeting.

April 11-12, 1984 - Florida personnel presented SED Network concept to education, mental health and other human service professionals at the Wingspread Conference Racine, Wisconsin (This was an invited conference with the "Florida Networking Model" as a point of departure for Wisconsin's future planning for children. Susan Yelton, HRS/CYF and Lee Sherry were both invited.)

April 12-13, 1984 - FMHI Children's Mental Health Workshop Community-Based Residential Programs.

April 18, 1984 - Bay Area Hospital Council approves SED Network plan for establishing a Chilren/Adolescent Psychiatric Unit sub-committee.

April 19, 1984 - SED Network staff attends Juvenile Offenders Educators (JOE) Conference, Tampa.

April 24, 1984 - A multiagency team from HRS District V presents "Florida's Multiagency Network" at the International Council for Exceptional Children 62nd Annual Convention, Washington, D.C.

April 30, 1984 - SED Network staff participate in the children's program site visit exit interviews at Mental Health Services of Upper Pinellas.

April 30, 1984 - SED Network staff investigate potential involvement of SED students at the Boyd Hill Nature Center, St. Petersburg as an activity for science curriculum.

May 1, 1984 - SED Network staff investigated potential of placing of SED students at Abilities Vocational Rehabilitation Center in the Work Adjustment/Training Unit.

May 1, 1984 - Legislature Budget Requests (Case Management and Elementary Day Treatment) presented to the District Mental Health Board, Board of Directors.

May 2, 1984 - SED Network staff participate in contract negotations between Pinellas County Schools and Pinellas Young People's Residential Treatment Homes (Adolescent Day Treatment Program.).

May 3, 1984 - ITEP Academic goals and objectives committee meeting.

May 3, 1984 - SED Network staff meeting.

May 4, 1984 - Juvenile Welfare Board denies partial funding of the SED Network Project. The Board funds only direct services separate from the School Board.

May 4, 1984 - Significant Case Review Committee meeting: CRC procedures and referral guidelines updated.

May 4, 1984 - SED Network staff present Case Management proposal and Information and Referral Guide to Horizon Hospital staff.

May 7, 1984 - JWB legislative advocate carries HRS District V funding priorites for for SED students to Tallahassee.

May 9, 1984 - FDLRS Gulfcoast and SED Network staff present "FDLRS/SED Network Cooperative Planning" at FDLRS Best Practices Annual Meeting, Tampa.

May 10-11, 1984 - FMHI Children's Mental Health Workshop "Case Review Committee".

May 14, 1984 - SED Network staff participate in FDLRS Advisory Committee.

May 15, 1984 - SED Network Advisory Committee meeting.

May 16, 1984 - SED Network staff met with Morton Plant Hospital staff to facilitate their participation in the SED Network Advisory Committee.

May 17, 1984 - YSAC Mental Health/ Substance Abuse Committee meeting.

May 17, 1984 - Data coding completed for video tape activity.

May 18 1984 - SED Network staff participate in Pinellas County School's development of a new report card for SED students.

May 23, 1984 - SED Network staff complete site visitations of community vocational training programs in HRS District V.

May 24, 1984 - SED Network staff meeting.

May 24, 1984 - SED Network staff and Juvenile Detention Center staff visit FMHI's Start Program and Tampa Children's Home.

May 24-25, 1984 - Network staff attend Vocational Education for the Handicapped Institute, USF, Tampa.

May 25, 1984 - Pinelias County School's SED Task Force Meeting; topic: Facilities for SED students.

May 25, 1984 - SED Network staff met with Director, Special Projects to begin development of a reduced budget for the 1985 urban pilot project.

May 29, 1984 - YSAC prepares a response to the changes in Chapter 394, the Mental Health Act. Objection is voiced to the exclusion of children as a specific group addressed by the revisions.

May 30, 1984 - ITEP implementation site visitation summaries completed.

May 30, 1984 - Network staff attend Florida Rehabilitation and Mental Health Services Workshop, Tampa.

May 31, 1984 - Florida Legislature adopts The Community Alcohol, Drug Abuse, and Mental Health Services Act.

May 31, 1984 - The legislative strategies sub-committee of the SED Network re-convenes to discuss 1985 strategies for advocacy for SED students.

May 31, 1984 - All goals and objectives (both academic and behavioral/affective) are completed by sub-committees.

June 1, 1984 - Teacher support activities for academic year completed and summarized.

June 4, 1984 - SED Network staff meet with FMHI staff to discuss non-residential programs in HRS District V; Meeting is to facilitate completion of entry/exit criteria for FMHI.

June 5, 1984 - Budget contingencies for 1985 SED Network project mean a reduction in the number of project staff. Decision is made to reduce staff to maximize carry forward funds for 1985.

June 5, 1984 - SED Network staff attend Treatment of the Offender at FMHI, Tampa.

June 7, 1984 - SED Network staff attend YSAC Juvenile Justice Committee meeting.

June 7, 1984 - Vocational education for SED plan and recommendations completed.

June 7-8, 1984 - FMHI Children's Workshop "Education/Mental Health Cooperative Programs" A multiagency panel from HRS District V presented the urban pilot project's progress.

June 11, 1984 - Preliminary 1985 budget figures prepared for Assistant Superintendent review. Figures represent reduced funding level.

THE MULTIAGENCY TASK GROUP: A PRODUCT DEVELOPMENT STRATEGY FOR THE MULTIAGENCY NETWORK FOR SEVERELY EMOTIONALLY DISTURBED STUDENTS

Statement of Problem and Purpose

In 1981, the Florida Legislature passed a statute with long-range ramifications for services to severely emotionally disturbed (SED) students. Specifically, the statute (1) designated local school boards as responsible for education programs and the Department of Health and Rehabilitative Services as responsible for mental health treatment and residential services when needed, and (2) stated the intent to have a multiagency network to provide education, mental health treatment, and, when needed, residential services for this population.

In 1983, Multiagency Network Pilot Projects began operating with the ultimate goals of (1) improving services to SED children and youth and (2) coordinating multiagency planning, implementation and evaluation of services. Educators and mental health professionals were brought together (some for the first time) to facilitate the development of new programs, products and plans. The purpose of this paper is to provide information to local school districts, community mental health centers and other human service providers about the multiagency process used to develop community oriented products.

The Multiagency Network for Severely Emotionally Disturbed Students staff have served as facilitators of the task group process in developing the following products:

Individual Therapeutic and Educational Plan (ITEP)
Case Management System for Children
Community-Based Classroom Program
Multiagency Staff Development Needs Assessments
Multiagency Evaluation Consortium

In each case a multiagency team of professionals was drawn together by common need and common concern to address the development of a product. Those groups of professionals included representatives from education, mental health, and other human service organizations.

These professionals represent 'natural resources' within the community. They are confronted daily with the difficulties of providing services to severely emotionally disturbed children. The products they come together to produce are viewed as new 'tools' or procedures to enhance services. The 'ownership' of the product is shared by the multiagency professionals who developed the product. In this way, the community seeks solutions and improvements to 'trouble areas' with practical methods and useful products. The following report is a description of the multiagency group process as piloted and facilitated by the SED Network.

Multiagency Task Group Process

Daily experiences that bring groups of people together to develop products which address the needs of the group is common in education and human service professions. The concept of cross agency or multiagency product development has been less common in actual practice. Included below are suggestions for multiagency participation in the task group process. The product to be developed by the group process fulfills needs identified by the local community. Although a general need for a product may be evident, the actual details of that product are developed by the task group.

Before a group of professionals can be convened to resolve a specific problem by developing a product certain questions must be asked. These questions include:

1. Who will comprise the group? (Who should be in the task group?)
2. What is the goal of the group?
3. How will communication among task group members be established?
4. How will that communication be maintained?
5. Will the group decision process be democratic, autocratic, laissez faire?
6. How many group members will be necessary?
7. How will members be recruited? By whom?
8. What pay-off can group members expect?
9. How will disagreements/conflicts be resolved?
10. If a group currently exists, who is the present leader?
11. Is the leader formally recognized?
12. Is there an informal leader or leaders?

Resolution of these questions may not be necessary before the group is convened and the product development process begun. The group planner should keep these questions in mind as the process begins.

When the decision is made to use the task group process to develop a product, certain considerations must be made. It is necessary to consider four major planning activities:

1. Topic/goal development
2. Personnel selection
3. Organization of the task group process
4. Meeting logistics

These four activities are interdependent. A decision in one area will have an influence on the others. The list, therefore, is not a hierarchy of activities but instead, represents four major areas that should be addressed by the organizer of a task group.

TOPIC/GOAL DEVELOPMENT

The first questions to ask as a planner of the task group are: (1) What is the goal of the group? (2) What is the anticipated product?

The nature of the task is broadly defined by the goal or product to be developed by the group process. Hall (1962) stated that the task is what group members subjectively define it to be as they respond to the situation (community needs) in which they find themselves. All of the internal features of the social system are likely to become important to task specifications. The task should not be narrowly viewed in terms of what the organizer intends, or only in terms of what the situation demands. Often, the planner of the task group may have difficulty deciding what the final product should be. The planner should spend time on analyzing the need for and function of the product. The planner should not be so specific in defining the product that it appears to have been already developed or predetermined. In its broadest sense, then, the definition of the task is based on the definition of the identified needs. Differences in behavior which appear between "situations" are the most general indication of differences in taks (Roby & Lanzetta, 1958).

RULE #1 - State as specifically as possible the anticipated product to be developed by the task group.

RULE #2 - Avoid predetermining the final product by limiting the group's options.

Rules one and two may appear incongruent at first. The art of defining the product is that the planner should be specific enough so group members have a clear idea on what task they will work. But not so specific that the task group process appears to be a "rubber stamp" of an already determined product.

Anyone who has been faced with the task of completing a thesis or dissertation may quickly see the parallel to Topic/Goal development problems in the task group process. Asking the right QUESTIONS seem to be the most difficult part of thesis or dissertation preparation. Researchers are always forced to ask the "right question" and the rest of their research naturally follows. The planner for the task group should define the topic or goal of the group clearly enough so that two things will naturally occur.

1. Task group members know exactly what is expected of them.

2. At the first meeting the purpose of that and subsequent meeting is defined clearly.

As suggested earlier, the four categories are interrelated. Once a clear, concise statement of the product has been completed the planner's next task is to recruit group members.

PERSONNEL SELECTION

Several factors must be addressed almost simultaneously at this stage:

1. Who are the most knowledgeable people in the proposed product area to ask to be in the group?
2. What incentives can be offered to a perspective group member to join?
3. From a 'political' perspective, which people should be included in the group?
4. What is the optimal group size?

Mailick & Ashley (1981) summarize: "The rationale for participation in collaborative activities is based on the recognition of complexity of human resources, the high degree of knowledge, technology and skill needed to meet them, the specialization of individuals and the resulting coordination and integration of these professionals."

The task group process is valued because it is assumed to be synergistic, that is, the services offered by the group are of greater scope and value than individual contributions separately applied would be (Werner, 1979). Hare (1976) in the Handbook on Small Group Research states that in order for a task group to succeed it must be able to generate skills and resources necessary to reach the group goal and respond to identified community needs.

The group planner, with a clear Topic/Goal statement in hand, can begin to list perspective group members and contact them to assess their interest in participating.

RULE #3 - Make a list of people that are knowledgeable in the product area.

RULE #4 - From that list, contact each perspective member and clearly describe the product they will be asked to develop. In this way their 'level of interest' in being part of the group can be assessed.

Concurrently with the personnel recruiting process, the planner must determine the number of task group members. Experience has dictated that six to ten people is the maximum number of group members per one group facilitator. Major generalizations based on research on the influence of group size on product development from 1950 through 1974 are summarized as follows:

> Although the size of the "natural" group varies with the age and other social characteristics of the population, casual work or play groups most often have only two or three members. Members are generally less satisfied with the group if the size is increased. Observers find it easier to identify leaders in discussion groups of about six members than in either smaller or larger groups (Hare, 1976, pp. 230-231).

Bray, Kerr, and Atkin (1978) offer suggestions for the consideration of the task group planner. As each additional member joins a group, the number of potential relationships between individuals and subgroups increases rapidly. This places more demands on the leader who coordinates the group activity. The time available to each member for communication decreases, the gap between the top participator and the others grows proportionately greater, and an increased proportion of the members feel threatened and inhibited as size increases. With the addition of new members, the resources of the group are increased so that a variety of problems may be solved more efficiently. After some point, depending upon the task, the addition of new members brings diminishing returns. The time for task completion is reduced at the expense of lowered efficiency per unit of time, and the range of ideas available is increased at the expense of greater difficulty in reaching consensus in the absence of any clear cut criteria for judgment.

The optimum size for a small task group may be five members. Members are generally less satisfied with smaller or larger groups. In smaller groups members may be forced to be too prominent. In large groups members may not have sufficient opportunities to contribute. In a group of five persons, strict deadlocks can be avoided and members can shift roles swiftly. To select the appropriate size for a task group, Thelan (1949) suggested the "principle of the least group size." The group should be just large enough to include individuals with all the relevant skills for problem solution. In a multiagency group process, where members represent community agencies, more members may be required to equalize the representation.

Bray et al. (1978) observed the work of groups of 2, 3, 6, and 10 university students. They concluded that it was not the actual size of the group that was important but the "functional size." As group size was increased, the number of non-participators also increased, resulting in a functional group size that was smaller than the actual group size. Usually in a small group, of five members, there is enough time to explore in some depth the opinions and feelings of each member of the group and to take them into consideration when reaching a group decision. But with a group several times as large, say 20 to 30 members, there is a tendency to consider the opinions of only the most vocal and high status members and to use some form of majority decision. This may sometimes leave a dissatisfied minority that is nevertheless supposed to remain committed to the group goal (Lindsay, 1976).

The larger the group, "the farther it will fall short of obtaining an optimal supply of any collective good, and the less likely that it will act to obtain even a minimal amount of such a good. In short, the larger the group, the less it will further its common interests." (Olson, p.36, 1971).

RULE #5 - Keep the group small; usually no more than 10 members.

Hare (1976) states: "for a group to be successful the members must share common identity and have some commitment to the values of the group." The proper selection of group members, i.e., those with an interest in the product, will enhance each member's commitment to the group.

The issue of incentive for perspective members to join and work in the task group can be addressed if the planner selects people knowledgeable in the product area. Professionals in education and human services, generally, are not well reimbursed financially. The norm is to volunteer and work for recognition more than 'cold hard cash.' Multiagency task groups are primarily comprised of professional human service workers (i.e., educators, mental health professionals). Luring a professional to a group is easiest when they have an interest in the product. Recognition for and a sense of control over the final product are additional incentives.

RULE #6 - Select professionals with the greatest commitment to the product or product area.

No organization or single professional can exist in a politically free environment. Politics is a common term defining the intricate interactions of people and groups usually vying for limited resources, power and control of a given environment or territory. In every community there are certain combinations of professionals that have proven to be either very effective or very disastrous. Also, the inclusion of one group member with a reputation for being 'stubborn' or 'contrary' may sabotage an entire group effort.

The task group planner must be aware of local 'politics' and local 'personalities' when selecting group members. If the planner is unsure of who to select, they are well advised to seek counsel from a trusted colleague who has 'been around for a while' and knows the local professional scene well.

RULE #7 - Avoid selecting 'political' adversaries to serve on the same group.

RULE #8 - Judge the 'political' nature of the proposed group before inviting perspective members.

Only in rare instances, where the 'hidden agenda' of the group is to bring adversaries together, should contrasting personalities be included in the same group. No matter how dedicated to the final product the members may be, fighting out past battles can ruin a group faster than any other type of conflict.

In some cases (i.e., small communities) there may be few professionals knowledgeable in the product area. Care must be taken to work out potential disruptive issues with this small group prior to beginning the product development in a task group.

ORGANIZATION OF THE TASK GROUP PROCESS

Professionals generally have very little time to spare for participating in a meeting which is "not going anywhere - in a hurry." Another key to successful group process is organization. Organization can be viewed from several perspectives:

1. pre-meeting planning
2. meeting in progress, and
3. post-meeting follow-up

Pre-meeting Planning

It is important to plan prior to the meeting to insure the appearance of being 'organized' and to avoid wasting group members' time. Establishing an agenda is a means of projecting the anticipated path of the meeting. The agenda need not be elaborate but sufficiently detailed to show the intended course of the meeting. The first meeting is generally an organizational and orientation meeting with the major agenda items being:

I. Introduction of group members
II. Review of Topic/Goal (reason for the meeting)
III. Discussion of background and/or issues associated with the anticipated product
IV. Suggestions from group on how they would like to proceed in subsequent meetings
V. Determine next meeting time and place
VI. Adjournment

Record keeping is a task that enhances group progress. Keeping complete minutes of each meeting is helpful. The minutes should follow the agenda items when they are transcribed. A tape recording of the meeting often helps the minute keeper (always a staff member) fill in gaps in their notes. Prior to the meeting a staff person is selected to be record keeper and recording equipment is available. Mailick and Ashley (1981) state that interprofessional collaboration includes communication and coordination by means of unified record keeping and written data feedback.

RULE #9 - Prepare an Agenda before each meeting.

RULE #10 - Prepare for and record minutes of each meeting.

Meeting in Progress

There exist several important concepts to be considered in conducting a productive meeting. These concepts include: (1) facilitation, (2) leadership style, (3) communication, (4) problem resolution, (5) consensus, (6) assignments, and (7) cohesiveness. Each concept is described below.

Facilitation. Invariably, the organization or person that organizes the meetings is viewed as the leader of the meeting. It becomes 'Joe's meeting," or 'the school's meeting.' In order to avoid the issue of 'whose meeting is it,' the planner should make clear to all participants that the planner's role is one of facilitator of the task group process.

RULE #11 - The group planner's role in the meeting is to FACILITATE the process.

Facilitating the process presupposes that the planner has not predetermined the outcome of the group process. Even though the planner has set the 'stage' for the meeting and has proposed the nature of the product, the task group needs to be reminded that their work is to bring an 'idea' into reality. Their efforts will result in generation of the final product. The facilitator merely makes the process flow so the committee may concentrate on creating the product. Facilitation of meetings is an art form. It is often easier to be dictatorial in the planner role and in effect make the group process a 'rubber stamp' process. Facilitation means, subjugating your own ideas as planner and encouraging the group to offer their own suggestions.

Dunnette, Campbell & Jaastad (1963) state that the facilitator must be able to reduce or eliminate the use of criticism within the group. For it is the presence of criticism that can contribute to the inhibiting influence on group members. The facilitator needs to be organized, articulate and dedicated to the task group process rather than the product. This person is responsible for the continuation rather than the stagnation of the process. The group facilitator must be able to summarize the group's ideas into a cohesive package. The facilitator is a good listener and a good reporter. The group will respond well to hearing their ideas expressed back to them in a clear and concise manner.

Leadership Style. Authoritarian, democratic and laissez faire leadership styles are the three most common types used in small groups. Characteristically the authoritarian leader is found to give out orders, commands and criticism. The democratic leader gives suggestions and stimulates self-guidance. The laissez faire leader gives out information when it is requested. More specifically a small group led by a democratic leader will follow these beliefs:

1. Full and free communication, regardless of rank and power.
2. A reliance on consensus, rather than the more customary forms of coercion or compromise to manage conflict.
3. The idea that influence is based on technical competence and knowledge rather than on personal whims or prerogatives of power.
4. An atmosphere that permits and encourages emotional expression as well as task-oriented acts.
5. A basically human bias, one that accepts the inevitability of conflict between the organization and the individual, but that is willing to cope with and mediate this conflict on rational grounds (Calhoun, 1980).

The most effective leadership style is that of facilitator of the group process. In this capacity the facilitator encourages the group through a 'democratic' process to expound upon their ideas. The facilitator may be 'autocratic' in times of turmoil or group confusion. The 'autocraticness' expressed by the facilitator is that he/she demands that the group process be allowed to continue. Through summarizing the group's suggestions and reiterating the goal (product to be developed) of the task group the facilitator should be able to move the group from a stalemate back onto the original track. The facilitator must always remain dedicated to the multiagency group process. All ideas, deeds, and suggestions made by the facilitator are oriented to helping the group move forward. Autocratic leadership of the task group will not work. Democratic leadership fosters communication and the creation of new ideas. Laissez faire leadership may be less threatening because the leader is less 'assertive.' The facilitator encompasses both democratic and laissez faire practices to remain as 'neutral' to the product as possible but as involved with the group process as possible.

Communication. A consistent problem in the task group process is that each member may not understand what the other members are saying. The key to communication is understanding the message. Open, uninhibited communication can occur if the facilitator acts as monitor and encourages silent members to express themselves. Two types of communication systems azre possible in the group process. Either a centralized communication network or a decentralized communication network can be used (Bales and Strodtbech, 1951). For large groups, authoritarian leadership, centralized communication networks, and groups in which members are in competition one finds an increase in productivity coupled with low satisfaction for the average member. (The central person is usually quite satisfied) (Hare 1980) Handouts/information sources are another form of communication.

Prior to the meeting the planner-facilitator should prepare whatever materials are deemed necessary to inform the members on the product area. Materials requested by the committee should be made readily available to the group. Handouts should be brief condensations of material. Graphic displays, charts, and lists are excellent ways to summarize data (Mailick & Ashley, 1981).

RULE #12 - Handouts should be concise, brief statements of information either in writing or in graphic form.

Monitoring of communication means filling gaps during the meeting, keeping members from monopolizing the meeting, and rephrasing comments to help clarify their meaning for other members. As noted above, the facilitator must be a good summarizer.

RULE #13 - Open communication is achieved through unbiased facilitation of the group process.

Problem Resolution. Poor communication may create many problems that can contribute to group failure. The member who carries an unresolved problem may sabotage or quit the group.

The facilitator needs to be sensitive to existing or potential conflicts and encourage communication and understanding to resolve them. Disagreements are a necessary part of the group process. However, no disagreement should be unresolvable if the right approach is used to explore the issues. The facilitator helps set a tone of openness, security and team spirit during the meetings. The group will naturally exert its power to maintain the equilibrium and stability of the group. Obvious problems will be resolved because task group members are well invested in the process.

Bales and Strodtbech, (1982) have proposed that groups work toward their goal by incorporating specific phases of problem solving. These phases emphasize (1) problems of orientation, (2) questioning or evaluation, and (3) decision making.

Hare has developed a sequence for problem resolution that includes the following steps: (1) a definition of the situation and commitment to the rules to be followed, (2) group members search for the needed facts or other resources required to solve the problem, (3) members adopt a division of labor in the form of appropriate roles and build group solidarity, and (4) decisions are made through the application of control in the form of leadership. At the end of the session (step 5) the group returns to the problem of commitment as the individual members decide how the decisions will be carried out once the group has disbanded.

RULE #14 - Expect problems to arise.

RULE #15 - Facilitate task group members to resolve problems by following logical problem solving steps.

One of the major crisis points in group product development is reaching consensus.

Consensus. Gaining consensus is a method to preserve the task group process. Consensus combines the best insights of all members to find a solution that incorporates all points of view (Hare 1980). Achieving consensus on a complex issue is a difficult task. The final product may be the result of a series of educated compromises by task group members who have their own professional biases. Seeking consensus is necessary to proceed from one step in the development process to the next.

The facilitator can encourage communication and cajole consensus. Sometimes compromises are not easily evident. Usually re-thinking and re-examining the topic/goal or product plan will open a path to a decision. It is easy to 'get lost' in a maze of details and lose sight of the product goal. The facilitator should be aware of this potential and guide the group by reminding them of the ultimate product. Guidelines for decision by consensus have been widely used. These include:

Facilitator's Guidelines for Decisions

By Consensus

(1) Do: Secure agreement to follow rules for consensus, that is, look for a solution that incorporates all points of view or is best for the group at this time.

Avoid: A zero-sum solution or using majority vote, averaging, or trading as conflict-reduction devices.

(2) Do: Give your own opinions on the issue. Approach the task on the basis of logic. Seek out differences of opinion to obtain more facts, especially from low-status members.

Avoid: Arguing for your own opinions.

(3) Do: Address remarks to the group as a whole. Show concern for each individual opinion.

Avoid: Confrontation and criticism.

(4) Do: Although the main function of the group coordinator is to help the group formulate a consensus and the main function of the group recorder is to record each decision as it is reached, all members should help formulate statements about solutions to which all can agree. Even if there appears to be initial agreement, explore the basis of the agreement to make sure there is agreement at a fundamental level.

Avoid: Changing your mind only to reach agreement.

(5) Do: Make it clear that each group member is responsible to apply the principle in new situations.

Avoid: Pressing for a solution because the time for the meeting is over. If consensus is not reached, postpone the decision until another meeting. Do more homework on the problem.

Consensus has also been defined as the process of reaching a decision based upon the acquiescences and support of the total group after discussion and debate.

RULE #16 - Consensus can be facilitated by reviewing the Topic/Goal statements and following suggested guidelines.

Assignments. In the event the final product is a major production, assignments to the committee members may be necesssary. Assignments may be as simple as reading a handout for discussion at the next meeting. Assessments may also involve accumulating information to be shared with the group. If the need for assignments becomes obvious, task group members should be allowed to volunteer to complete the task.

Dunnette (1964) has developed a form of Brainstorming that results in individual assignments. Based on the notion that group brainstorming is not completely successful, Dunnette suggests that individuals who are given the task of brainstorming independently, yield a much greater return than group brainstorming. These individuals then present their results to the group, this allows the group to resolve problems and reach decisions on information generated by the individuals.

RULE #17 - Assignments should be short, relevant and geared toward information needed to ease product development.

Cohesiveness. The concept of cohesiveness is central to the task group process (Fodor & Smith, 1982). Cohesiveness can be defined simply as "sticking together." A group that has developed ownership of the process, realizes the power of the group, and experiences recognition for the development of products will be cohesive.

Factors contributing to group cohesiveness are: (1) ownership, and (2) recognition. One of the major advantages of the task group process is that group members feel a 'part of the product,' they have ownership of the final product. They can personally identify with the product they helped develop. The group members then advocate for and use the product more freely. Group members must feel that the process belongs to them, not the planner or facilitator.

An additional incentive for participating in the group is recognition for the development of the product. By successfully facilitating the group the planner allows the members to 'strut their stuff.' The final product is designed through a multitalented effort. Each participant owns an equal share of the product and can thus receive the recognition due them. The task group becomes a cohesive body.

RULE #18 - Allow group control of product design.

RULE #19 - Recognize each member's contribution to the process.

RULE #20 - Facilitate! Don't dictate!

These three rules will enhance the cohesiveness of the group and increase the member's interest in participating in the group.

POST MEETING FOLLOW UP

The creation of products are accomplished during the meetings of a multiagency task group. However, the work does not stop as the meeting adjourns. The professionals comprising the group, unless given an assignment, generally do not have tasks to complete until the next meeting. This is not the case for the facilitator and/or his/her staff.

The facilitator will actualize the suggestions of the group. Following through on the transcribing of minutes, gathering of data requested by the group, the writing of draft products and preparing the agenda for the next meeting must be completed by the facilitator to support the task group.

The most effective ways to use the task group process are (1) as a generator of ideas, (2) reviewer of draft products, and (3) overall monitor of the process and product (Dunnette, 1964). The group in subsequent meetings 'fine-tunes' the draft product until consensus is reached on the final product. The facilitator should always be committed to carrying through with the necessary details that result in the product's development.

RULE #21 - The total committee serves as the (1) generator of ideas, (2) reviewer of draft products, and (3) monitor of process and product.

An additional post-meeting activity is the writing and typing of the minutes from the meeting. The minutes form the documentation of the product development process. In times of dissension the minutes may be used as a reference to prior discussions and previous decisions (Mailick & Ashley, 1982). The minutes should follow a consistent format such as the one suggested below:

Heading:	Title of Group Date of Meeting
Members:	List both present and not present members of the group. Use full name and professional titles
Body:	Follow the items on the agenda. Use agenda items as major titles of paragraphs in which comments, discussions, and decisions are recorded Record motions and seconds and the vote on the motioned items. Credit comments to members to increase recognition and establish patterns of comments.

General Considerations: Keep minutes short, concise, and current. Minutes should be sent to each member of the committee, with the next meeting's agenda prior to that meeting. The standard procedure may be:

(1) Memo announcing (reminding) the next meeting

(a) where
(b) when
(c) how long

(2) Agenda for next meeting (ask committee for their suggestions on items to cover)

(3) Minutes of last meeting

(4) Handouts to be reviewed at the next meeting

RULE #22 - Take minutes and use them as documentation of the task group process.

SUMMARY

These 'practical' suggestions for using the task group process in multiagency product development can serve as guidelines to the facilitator. The practitioner following these guidelines may expect a high probability of success in using the task group process.

Remember:

Although, in certain circumstances, an individual is more efficient in developing a product, the task group process is more effective. In addition, the members of the task group will serve as advocates for their own product(s). By properly selecting group members from multiple agencies which will be called upon to use the product, greater receptivity and acceptance of the product(s) will result. In the context of multiagency cooperation, the task group process out weighs the single individual's effort.

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COMMUNITY-BASED CLASS PROGRAM PILOT SUMMARY

This report has been prepared to give the reader a general understanding of the concept of the Community-Based Class Program. Included in this report is the 1) rationale for the program's development, 2) brief description of the program, 3) 1984 objectives, 4) evaluation of the results of the 1984 objectives, 5) areas of concern effecting the future of the Community-Based Class Program, 6) projected operational objectives by the Community-Based Class Program staff.

The data used in the report was provided by Mental Health Service of South Pinellas (MHSSP), the Child Guidance Center which is the fiscal agent for the pilot. It spans a time constraint of January, 1984 - March, 1984. Data for the period of April-June, 1984 was not available for this report. A comprehensive description of the Community-Based Class Program is available through the SED Network.

STATEMENT OF PROBLEM

The Community-Based Classroom Program (CBCP) was developed to provide a unique educational and therapeutic model to serve emotionally disturbed adolescents whose psychiatric diagnosis come under the broad heading of Conduct Disorder with the following DSM III descriptions:

1. undersocialized, aggressive (312.00)
2. undersocialized, non-aggressive (312.10)
3. socialized, aggressive (312.23)
4. socialized, non-aggressive (312.21

This population of severely emotionally disturbed students who because of specific common characteristics have experienced social and educational failure in both school and the community. These characteristics include but are not limited to:

1. long history of self-destructive, volatile, aggressive behaviors;
2. nonresponsiveness to academic or traditional therapeutic programs;
3. experience of failure in the SED Center's classroom;
4. have been fostered in a dysfunctioal family unit;
5. involvement with the court system;
6. disruption of the school environment;
7. success with one-to-one instruction;
8. nonresponsiveness to treatment in available residential facilities;

9. possible threatening behavior to students and staff;
10. displays uncooperative behaviors;
11. inability to adhere to traditional behavior management techniques and respond favorably to school authorities;
12. inappropriate social interaction skills.

Students to be considered for placement in this program generally have had extensive involvement with the Juvenile Court System as well as with Health and Rehabilitative Services. However, the success of the Community-Based Class Pilot Program depends largely upon the cooperation of those agencies in the community who provide services to these students.

PROGRAM DESCRIPTION

The major objective of this program is to separate the unsuccessful child from SED Center peer stimulation and place the student in an intensive educational and therapeutic environment. The uniqueness of this program focuses on the collaborative efforts of the staff. The masters level teacher and teacher's aide, funded by the School Board of Pinellas County and the mental health professional, funded by the Juvenile Welfare Board work cooperatively to plan and to implement a therapeutic and educational program. The staff works closely with parents and students through individual, group and family therapy. The teacher and the Mental Health Therapist, will coordinate multiagency services such as:

1. Richard L. Sanders School, Pinellas County School System
2. Mental Health Services of South Pinellas, Child Guidance Center
3. Health and Rehabilitative Services
4. Sixth Judicial Circuit Court
5. Juvenile Detention Center
6. SED Network

The program is housed in a community facility in the student's neighborhood. A modified school day permits students to attend classes on a Staggered Schedule. Specific procedures for identification, placement, and dismissal from the Community-Based Program have been developed by the multiagency development team. The Community-Based Class Program was initiated January 4, 1984.

ADVANTAGES OF THE COMMUNITY-BASED CLASSROOM PROGRAM

1) provides a neutral, nonthreatening environment for students
2) relieves the Center of disruptions to the other students' learning process
3) removes peer pressure

4) fosters parental involvement and student's independence

5) offers an educational alternative to suspension/expulsion

6) provides the Center program an alternative which was previously unavailable

7) offers educational and therapeutic services on an individual basis, and

8) provides the opportunity to gear services more to the individual student

OBJECTIVES

The Community-Based Class Program has been charged with the following objectives to be completed during the 1984 school year:

1) To serve eight youth during the funding period (through 7-31-84).

2) To serve at least ten parents or surrogate parents during the funding period.

3) To provide 2200 staff hours of direct service during the funding period.

4) To obtain an 80% consumer satisfaction rating when surveying all client families (conducted according to JWB specifications).

5) The program will provide an average of four hours of services per day to each youth. Youth will participate at least 70% of the time. (A report of the number of class hours provided each quarter and the average daily attendance during the quarter will be developed).

6) The Community-Based Program will provide and extensive therapeutic component with emphasis on family involvement as follows:

   (a) Individual therapy to the youth client in at least two sessions per week.
   (b) Group therapy to the youth client in one session per week for the first three months of treatment and at least two sessions after the first three months of treatment.
   (c) An average minimum of one family therapy session, group therapy session or educational activity for parents and other family members as appropriate per week. The program will conduct at least one home visit with the family unless special conditions preclude this.

7) The program will conduct at least two (2) coordinating meetings involving the following community resources:

(a) Health and Rehabilitation Services
(b) Sixth (6th) Judicial Circuit Court
(c) Community Mental Health Services
(d) SED Network
(e) Other human services provider agencies or community groups.
(f) Meetings involving community resources will be either on an individual or group basis.

8) Participating youth will achieve academic improvement which is at least at a rate equivalent to the academic achievement of those youth participating at the Sanders SED Center as measured by standardized tests.

(9) To obtain 80% satisfaction rating in surveying other agencies which have provided support services to children or to the families of children participating in the program itself.

(10) Fifty percent (50%) of participating students will be readmitted to the Sanders SED Center or an appropriate community program which is less restrictive (i.e., job placements, day treatment, outpatient services) as determined by the Department of Education for Exceptional Students (DEES), Staffing Team.

EVALUATION OF OBJECTIVES

The following is a summary of the Quarter II Report prepared by Mental Health Services of South Pinellas, Child Guidance Center. Results of each objective is written based on the results of 2nd quarter (January, 1984 - March, 1984) time frame.

A. Measurable Objectives

(1) Program services were provided to eight youth which met the objective. Two of these students were nineteen years of age and were not directly involved with the Mental Health Professional. Those were participants enrolled in the program by Richard L. Sanders School administrators.

(2) Eight parents were served during the second quarter. This falls within the objective of 10 for the funding period.

(3) Staff hours during this quarter total 1128 which meets the objective of 2200 staff hours within the funding period.

(4) Consumer satisfaction study will be administered during the third quarter and reported during the fourth quarter. Data for evaluation was not compiled during the second quarter as the program was initiated during this time.

(5) The total number of patient days "enrolled" in the program was:

1) January - 0 days
2) February - 6 days
3) March - 48 days

The total number of patient days "attended" was:

1) January - 0 days
2) February - 6 days
3) March - 32 days

The monthly average of hours of service available to students was:

1) January 3 - February 17 - 7 hours daily
2) February 20 - March 31 - 8 hours daily

The average daily enrollment and average daily attendance (by students) was:

1) January - 0 enrollment; 0% attendance
2) February - .3 enrollment 83% attendance
3) March - 2.8 enrollment 66.6% attendance

(6) The therapeutic component of the Community-Based Classroom Program included:

a. Average of four individual therapy sessions per student served which is twice the objective of a minimum of two sessions per student per week.

b. Group therapy sessions averaging 1.5 sessions per student per week which exceeds the objective by half of one session per week during the first three months of service.

c. Average of three family therapy sessions, group therapy session or educational activity for parents and other family members as appropriate per week. This exceeds the average minimum objective of one per week by two per week. Each family has received an average of three home visits which exceeds the measureable objective by one home visit each.

(7) A coordinating meeting was held on March 3, and another one is being planned for March 30. This meets the measurable objective of two meetings.

(8) Standardized achievement testing is being planned and will be performed by Sanders staff during the next reporting period. Testing was unable to be performed during this quarter due to program just being initiated.

(9) Satisfaction rating surveys of other agencies which have provided support service to children or the families of children in the program will be performed during the third quarter. A goal of an 80% satisfaction rating is anticipated to meet the objective.

(10) The objective of 50% of participating students being re-admitted to the Sanders SED Center or other less restrictive community programs as determined by DEES will be evaluated at the end of the third quarter. This is in compliance with the objective requirement that the students have participated in the CBP for six months. (This includes an additional evaluation following re-admissions of satisfactory participation in the SED Center Program for an additional six months.)

(11) Arrangements are to be made vis a vis the SED Network to place on the SED Evaluation Consortium's agenda development of of effective evaluation tools to determine the success of the program in conjunction with the objectives. Profiles of each student have been requested to accompany this quarterly report. It is felt that the current status of the program is meeting these expectations to the best extent possible. This procedure meets the objective of the coordination of efforts to evaluate the program by CBCP, SED Network and the SED Evaluation Consortium.

Several areas of concern that appeared to affect attainment of objectives and program operation were indentified by the Community-Based Class staff. However, steps are being taken to alleviate each concern through cooperative efforts of the Department of Education for Exceptional Students, Mental Health Services of South Pinellas, Sanders staff and the SED Network staff.

These areas of concern are:

a) Mental Health staff was not hired until late into the quarter, February 20, 1984.

b) School district unable to provide transportation to students at this time.

c) Attitude of hesitancy to make referrals by Sanders teaching staff. (Note: A meeting was held on February 29, 1984 to encourage the referral process which resolved this problem.)

d) Unanticipated degree of the severity of disturbance of the students enrolled in the program and the subsequent conduct problems with Enoch Davis Center staff and participants in other programs. (Note: Relocation is currently being considered which would be presented for JWB approval.)

e) Two students in the program are nineteen years old. (Placed by Sanders.) One is currently in the process of being staffed out of the program and into Adult Day Treatment. The status of the other nineteen year old is currently being reviewed.

OPERATIONAL OBJECTIVES

Primary Operational Objectives for the Community-Based Classroom Program this quarter were:

a) Initiate pilot program

b) Hire staff

c) Establish/clarify procedure for the admission of the students

d) Begin providing therapeutic services

e) Combine the treatment plan with the IEP to form the ITEP

Operational objective for the next quarter are: (April, May, June, 1984)

a) Redetermination of the program site

b) Earlier notification to CBCP staff regarding staffing or students being considered for referral. (Note: this does not mean that decisions on referrals have been made prior to the staffing.)

c) Moderation of the severity of disturbance of students referred to the program.

CASE MANAGEMENT SYSTEM DEVELOPMENT: UPDATE

DEVELOPMENT OF A CASE MANAGEMENT ASSOCIATION:

Since the report to the State SED Advisory Board in January, 1984, the multi-agency group development process of a comprehensive children's case management system has continued. A sub-committee was convened from the larger Case Management System Development Committee (CMSDC) and was comprised of professionals from education, mental health, HRS, community agencies and the District Mental Health Board. The sub-committee's task was to develop a case management system or systems to be reviewed and accepted by the larger CMSDC.

From February, 1984 till May, 1984, five very significant meetings of the sub-committee were held. The resulting product of this committee's work was a Legislative Budget Request (LBR) to fund three professional case managers and 2½ case management technician positions. These staff would be employed by the three community mental health centers in the District; Mental Health Services of Upper Pinellas (MHSUP), Mental Health Services of South Pinellas (MHSSP) and Human Development Center of Pasco.

The unique concept to be fostered by the sub-committee was that of the Case Management Association. The Case Management Association is viewed as the District's most vialble means of maintaining communication and resolving problems among the various community service providers. The Case Management System Development Committee (CMSDC) was reformed to become the functional Case Management Association.

The Association represents the first full and equal partnership of agencies which both plan for, fund, and provide services to SED children. The Association has become the community's open communication forum to resolve important issues as the District begins comprehensive case management services. The case managers requested in the LBR are not scheduled for funding until 1985. The Association will work to 'iron out' issues prior to the case managers assuming their duties.

CASE MANAGEMENT ISSUE PAPER:

During an early CMSDC meeting an issue was discussed which prompted SED Network staff to develop a paper explaining whether case managers should be mental health therapists or whether they should be solely assigned case management duties. The paper entitled: Case Manager vs. Therapist-Case Manager: Pros and Cons were offered to the Committee for consideration. The paper concludes that a case manager need not be a therapist but should have the skills of a therapist to establish rapport and be supportive of their clients.

CASE MANAGEMENT SYSTEM
LEGISLATIVE BUDGET REQUEST

Problem/Need

State of Florida Department of Health and Rehabilitative Services, Chapter 10E-4, Fla. Administrative Code Community Mental Health Regulation defines High Risk clients as:

> "...individuals of all ages in State treatment facilities and individuals of all ages in the community who are either being transferred into or have been transferred out of State treatment facilities."

Children placed in State Mental Health facilities (SMHF) are mandated to receive case management services as do their adult counterparts. These children with debilitating emotional problems are classified as being severely emotionally distrubed (SED).

Presently in the Pinellas/Pasco region 270 children are labeled SED by the school systems. These children are served primarily in special centers for SED students (Pinellas only) and Day Treatment programs (3 Pinellas, 2 Pasco) which are cooperative school/mental health programs.

In addition, 47 children are on a waiting list for residential services. Five (5) children are placed in the SMHF. An undetermined number of children frequently are served in local psychiatric inpatient facilities. All of these 'high risk' children are in need of specialized case management services.

Treatment resources available to the SED population are limited and should be provided in concert with other ancillary community services that will enhance the effects of treatment. Many times a contributing factor to the abnormal behavior of the SED child is the environment. The home situation can be improved by linking the child's family with appropriate services. Parents in many cases are unfamiliar with available services. They are not always emotionally prepared or fully understand which services to seek. Treatment for a school aged SED child requires a coordinated effort among the school and mental health system, the parents and the community. In many cases, the Juvenile Justice System is also involved with the child. All too often, the SED child is not given consideration for having a severe handicap and is incarcerated and denied the necessary continued treatment.

A case management system designed to address the special needs of the SED child and family is needed to assure continuity of care and to improve the quality of life for all parties. A comprehensive case management system will also reduce the need to place children in the SMHF.

Proposed Solution

District V proposes the development of a district-wide case management system for SED children that integrates, through written agreement, both public and private services. The Case Management System will provide a much needed linkage among the community services for SED children, adolescents and families the State Hospital System, and local service providing agencies.

The proposed District V Case Management System has been developed by a multiagency group process facilitated by the SED Network. Representatives of the two school systems, three mental health agencies, District Mental Health Board, Pinellas Mental Health Association, and Health and Rehabilitative Services comprised the writing committee of the District V Case Management System Committee. The larger committee also includes representatives from local psychiatric hospital facilities as well as the private sector.The uniqueness of the District V Case Management System is that it is the result of a multiagency development process conducted by the same agencies which will implement the system.

Mission Statement

The District V Case Management system for SED children/youth has as its basic guiding philosophy sixteen interrelated goals or outcomes that will result by implementing the proposed comprehensive system. The mission statement of the District V Case Management System states:

A case management system is needed to provide Severely Emotionally Disturbed (SED) Children/Youth and their families a comprehensive continuum of mental health and related care services. Case management is an advocacy activity conducted by a professional case manager to improve the quality of life of the case management consumer. Anticipated benefits for consumer and community are:

1. Eliminate the need to place clients in out of state programs.

2. Reduction in number of referrals to the State Mental Health Facility (SMHF)

3. Reduce the length of stay of the client in residential treatment.

4. Maintain the client in the community in the least restrictive environment.

5. Maintain client and family integrity by serving the child and family locally.

6. Increase referral options open to children screened by District V Case Review Committee (CRC)

7. Promote the multiagency process facilitated by the SED Network.

8. Identify and eliminate 'gaps' in the service delivery system by a multiagency process including the resources of:

   District Mental Health Board: District V Plan
   Juvenile Welfare Board: Needs Assessments
   SED Network
   Pasco/Pinellas School systems
   Health and Rehabilitative Services: needs and other assessments
   Other multiagency programs

9. Advocate for the creation of readily accessible new services

10. Advocate for the improvement and increased accessibility of existing programs.

11. Use of existing communication and service networks to increase service for clients and reduce duplication of effort in service delivery.

12. Enhance the cooperation of Education, Mental Health, Juvenile Justice System and other service agencies.

13. Reduce the cost of services to SED children/youth and families.

14. Improve hospital discharge planning and continuity of care.

15. Involve community mental health services in the educational centers for SED children/youth.

16. Help insure continuity of care for SED children and families.

Admittedly, these sixteen (16) outcomes are ambitious. The success of the multiagency case management system development process is one indication that District V is actualizing multiagency cooperation. These goals are attainable through mutual cooperation and pooling of community resources.

Consumer entry into the case management system may occur at different points in the continuum of services. Service providers may identify a client who needs additional case management services. The vast majority of SED children are identified and served by the school systems. The proposed case management system will address the needs of this population. The following list represents entry points, by highest priority, into the District V Case Management System.

1. Presently placed in State Mental Health Facility (SMHF)
2. Presently placed in a residential treatment
3. Presently hospitalized in local facility
4. Approved by Case Review Committee for funding of a placement and placed on a waiting list
5. Placed in an SED Center/Day Treatment Program
6. Referred to Case Review Committee but not approved for funding
7. With major diagnostic problem and not referred to CRC
8. Directly referred by practioner for Case Management Services.

The majority of children presently identified as recipents of the proposed Case Management services are located in the SED Center and Day Treatment programs located in both Pasco and Pinellas counties. Due to the high potential for these 'at risk' children to require more restrictive programs the Case Management system has been designed to prevent their movement into the SMHF.

Case Managers

Funding for three full FTE case managers to be employed by the three Mental Health Centers in the district is requested. In addition, the two Pinellas Mental Health Centers would each receive one full FTE Mental Health Technician. Pasco, due to present levels of identified SED consumers, would receive one half (1/2) of an FTE Technician.

The mental health centers are already conducting case management activities for 'high risk' children placed in the state hospital. This proposal is for funding of three full FTE professional positions to support the center's required case management activities. The intent of this system is to extend the case management services to children placed in residential, center and day-treatment programs and not limit it to only children placed in state hospitals. Due to this additional support it is anticipated that fewer children will need to be served in the State Mental Health Facilities (SMHF).

The case load for each case manager and technician will be based on three types of case management clients. These three types are: 1) active client, 2) semi-monitoring, and 3) monitoring client.

An active client is considered to be a consumer who has no other identified case manager. This would be a child with few previous agency contacts and for whom a complete case management plan has never been developed. The semi-monitoring client is one who has been and is presently being 'case managed' by a service agency. An example of this type would be a child in HRS custody who has an HRS counselor assigned to the case. Clearly the agency case manager would not have to provide full service to this child but would in cooperation and joint planning with the HRS counselor fulfill only those functions not already addressed. Hence, the 'semi-' or partial aspect of monitoring to see that an overall case management plan is implemented.

The third type of client would be the monitoring client. This would be a child placed in residential or state hospital treatment, who for at least the time of their stay, would be case managed by the residential program. The agency case manager would then only 'monitor' the case management plan to insure the program is continuing to serve the consumer's need. At the time of discharge planing the consumer would change to active or semi-monitoring status.

Case Management Association

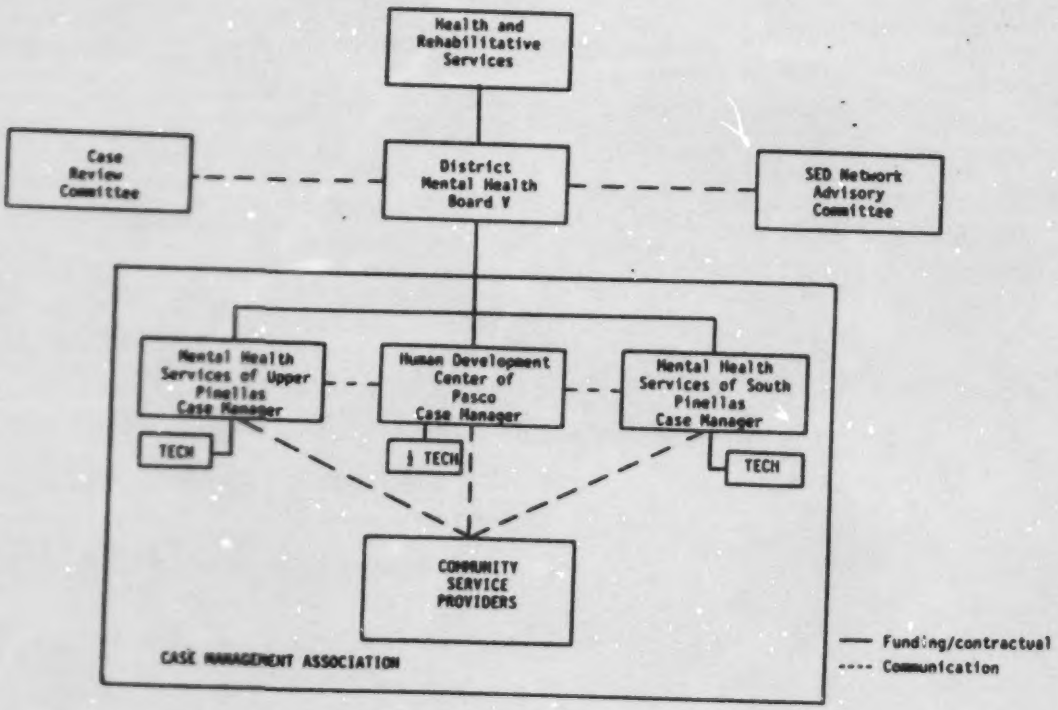
One of the unique features of the proposed Case Management System is the introduction and continued development of a Case Management Association. The association concept is selected to typify the equal partnership of all agencies involved in providing case management services.

No Association member's needs will be considered 'less' than others due to the size of the county population or agency budget. The work of the Association is to insure quality services for SED children and their families through cooperative efforts.

The Case Management Association diagram represents the partnership of the three case managers, technicians and community service providers. Communication (represented by dotted lines) networks will be established to enhance the speedy delivery of direct services to clients. The heavy lines represent funding and contractual relationships established between the funding body and each case manager agency. These relationships will be developed by the funding body and case manager agencies with the assistance of the Case Management Association.

DISTRICT V

CASE MANAGEMENT ASSOCIATION



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The subcommittee of the SED Network which has developed the case management system and this LBR will form the fundamental membership of the Case Management Association.

The Association's mission will be to 1) facilitate communication among agencies, 2) be a forum for problem discussion and resolution, and 3) serve as an advocacy and planning body for continued and improved case management services for SED children. As a continuing subcommittee of the SED Network, the Association will benefit from the ongoing activities of the SED Network staff in promoting the multiagency process which was used to develop the system. SED Network employee(s) will serve as staff to the Association members and will be responsible for 1) scheduling and arranging places for regularly scheduled Association meetings, 2) take and prepare minutes of meetings, 3) serve to facilitate the ongoing multiagency development and problem solving process. At the pleasure of the Association, the staff will also 1) research better ways to conduct and expand case management services, 2) prepare public relations materials, 3) present the concept of the case management association to other professionals both locally, state and nation wide.

The Association will serve as the guiding and advocacy body of the case management system. Through the Association direct services to SED children will be enhanced. The Association, prior to funding, will continue to explore case management issues and prepare the way for implementing case management services when the funds become available. The Association is now and will remain cognizant of certain inherent differences between Pinellas and Pasco counties which will necessitate slightly different implementation of daily case management services. The Association will assist in the development of unique procedures to meet the needs of both Pinellas and Pasco counties' SED populations.

The majority of SED children and youth to benefit from this case management system are served by the two public school systems. The Association will have representatives from the two school systems as members. Through the Association, better communication among mental health, HRS and the school systems will result.

The Case Management Association represents a major step forward in multiagency cooperation and service provision. The equal partnership of each member and their continued dedication to providing the most appropriate services will bring about improvements in the quality of life of SED children/youth and their families.

CASE MANAGER VS. THERAPIST-CASE MANAGER: PROS AND CONS

Professionals concerned with providing case management services for both children and adults are often confronted with practical and philosophical issues. After grappling with the question of what constitutes case management, professionals are still faced with the all important question: Who should complete case management activities?

Historically, social work professionals have been identified as the managers of client cases. Heavy emphasis involving (1) the daily problems of the family, (2) coordination of employment and housing, and (3) providing food resources typifies the social work case management function.

The funding in 1965 of the Community Mental Health Centers Act of 1963 inaugurated the development of Community Mental Health Centers (CMHC). One of the primary functions of the CMHC is to provide Case Management services for deinstitutionalized chronically mentally handicapped adults.

The expansion of the CMHC to serve children and their families extended the role of traditional case managers. Services to children required the establishment of new roles and responsibilities for already overtaxed adult case managers. Time and funding constraints have limited the development of a comprehensive system of case management like that provided for the chronic adult.

Public Law 94-142, the Education for All Handicapped Children Act of 1975, mandated that public education extend free, appropriate, related services to all handicapped children. The severely emotionally disturbed (SED) child falls within the group of children affected by the Federal mandate. Often times the emotionally disturbed child comes from a dysfunctional or single parent family. The need for case management services for SED children/youth and their families is a total community concern.

The question of who should provide case management services for SED children remains unanswered. Two issues require consideration based on traditional roles of CMHCs and schools. The CMHC has a long and generally positive history of providing case management services for adults. Should the CMHC extend their services to SED children? The public education system has a commendable history of service to handicapped children. Should school personnel extend their sphere of services and provide case management for SED children? The issue has not been reconciled to the satisfaction of either Mental Health Centers and/or the schools. This paper will not address itself to the resolution of this issue, but will examine the case manager as therapist or case manager as specialist.

Since CMHCs are providing case management services for adults and to some extent, children, this paper will address the issue of whether case managers as opposed to therapist doing case management should be employed to offer the service to the client. Should the case manager be the client's primary therapist, or a professional assigned exclusively case management duties?

Case Manager as a Unique Role

Hansel, Wodarczyk, & Visotsky (1968) reviewed a two year project that was designed to recruit and train para-professionals to become Mental Health Expediters. They defined an expediter as one who .... "coordinates a number of events to see that they happen and in such a manner that an overall good outcome occurs."

The expediter forms a link between client and community and performs the folliwing jobs:

1. Maintains roster of service agencies
2. Establishes and maintains contact with agencies
3. Processes interagency referrals
4. Makes sure clients keep appointments
5. Investigates client's concerns about services
6. Informs professionals about resources
7. Conducts public relations activities about expediter's roles

The expediters in this study were employed by the local Mental Health agency. The expediter was not considered a mental health therapist although an emphasis was placed on learning counseling techniques. Other mental health professionals working with the expediter viewed the expediter's role as: "linker, advocate, arranger, messenger carrier, negotiator, and convener." This model is an example of the case manager not being responsible for providing therapeutic services.

Although similar to work reported by Hansel et. al. (1968), Granet and Talbott (1978) revised the expediter role by suggesting that expediters be trained as "Continuity Agents." Garnett and Talbott viewed the vast mental health system as a complex and often uncoordinated system of separately funded and administered programs existing in concert with a larger human-service network. Unlike the expediter, whose scope is community-wide, the continuity agent's primary focus is on case management within the mental health system. A secondary responsibility extends to the human-service network.

The continuity agent would be an already established mental health professional, such as, a social worker, psychologist, or psychiatrist trained to provide continuity of care services. The continuity agent performs similar functions as the expediter including advocacy and client support. "He would in effect be the adviser-ombudsman rather than a therapist. The continuity agent would have a role that consitutes a bridge between systems and, more important, between human beings." (Granet & Talbot, 1978, p. 132).

Sullivan (1981), in his chapter on Case Management in the text The Chronic Mentally Ill suggests that many professionals recognize "case management as a new role." Federally funded social services are mandated to provide case managers or at least case management functions.

> "The case manager was seen as the worker for the individual in need and, in their way, acted as the sole agent who had the 'portfolio', so to speak, for the person" (Sullivan, 1981, p. 124).

Sullivan identified the case manager as a professional that knows the client very well. He does not suggest the need for the case manager to be the client's therapist.

> "In summary, the need to have a case manager as an integral role in the existing human services is well documented. The role emerges as an additional specialty..." (Sullivan, 1981, p. 125).

Elkins (1979) in an unpublished paper on case management states his position without need for interpretation:

> "... the case manager provides no service other than management services." He further states that: "The concept of the case manager as sole coordinator is the more prevalent approach..." (Elkins, 1979, p. 5).

Johnson and Rubin (1983) reviewed case management functions in light of which professional group is best prepared to provide the service. As noted in the opening paragraphs of this paper, the social worker has been most often associated with case management activities. Ambiguous role definitions, lowered status and the orientation of social worker graduates that CMHC work is therapy not case management, fosters a dichotomy between case management and therapeutic roles. The case management role is not exclusively a social worker function and may not be considered a positive role for any mental health professional group (Johnson & Rubin, 1983).

Lamb (1977) perceived the role of the case manager not as an in-depth psychotherapist but rather one of providing support to the client with a focus on day-to-day realities and survival. The professional case manager needs skills to develop rapport with the client but not develop a deep therapeutic relationship. The issue of which professional group is best trained to be case managers is still open to debate. Apparently the ability to relate positively to the client is the primary ingredient for successful case management. Many social service training backgrounds are based on rapport establishing. Social work is only one example of several that take this approach.

Neither Here Nor There

The Joint Commission on Accreditation for Hospitals (JCAH) publishes a Balanced Service System definition of program components necessary for approval of accreditation. Under the heading of Case Management Services, the JCAH publication addresses the various functions of Case Management. JCAH identifies case management as a primary function of service provision to the mentally ill client:

> "Programs may fulfill the functions of the case manager with persons who are called primary therapists, advocates, or patient representatives. The title assigned to the person who fulfills the case management function and the professional discipline of that person are both unimportant, so long as the responsibilities of the case manager outlined above are assumed and the necessary action takes place".

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JACH does not advocate either position: (1) the exclusive case management role or (2) the primary therapist as case manager. They have outlined functions that need to be fulfilled by some identified professional. In their eyes, the provision of service is more important than the title of the professional who provides it.

Hays (1982) in her discussion of case management addressed the advantages of the Broker/Advocate and Primary Therapist approaches:

> "A case manager carrying a normal client case-load and functioning as a broker/advocate has more time to carry out case management functions than a primary therapist case manager who also engages in individual counseling sessions with his or her clients. Advocates of the broker/advocate approach propose that a case manager can link a client to an individual therapist just as the client can be linked to any other service provider. However, if the case manager is not adequately case managing the client, no one else will fill that role.
>
> Conversely, there are some benefits to a client's case manager also serving as his primary therapist. For one, the case manager is able to develop a more in-depth relationship with the client as a result of the counseling experience. For another, communication about the planning decisions based on the counseling activities are more direct in that the counselor and the case manager are one and the same. It also eliminates the opportunity for the client to 'play off' the counselor against the case manager, if the client is inclined to do so" (Hays, 1982, p. 457).

Hays explored several other methods of case management provision. These include, (1) the Team and (2) the Multidisciplinary and Multilevel approaches. The Team approach utilizes a group of professionals, each offering a certain type of expertise and experience. The latter approach encourages staff with certain skills or roles to work with the client as their professional background dictates. The multilevel approach adjusts service provision based on the level of expertise and training of the staff. For example, a beginning level social worker may perform certain basic and simple case management duties while an experienced psychologist would be involved with the client at a more intensive or sophisticated level. This option is cost effective since the salary level of the staff will be commensurate with the service level. The approach has the inherent problem of coordination of the efforts of many people per client as opposed to the simpler system of an individual case manager per client.

Therapist as Case Manager

Lamb (1977) suggests the main function of the case manager is to be a support to the client with an orientation to client needs for survival. He frowns upon the exclusive use of psychotherapy as an effective approach to helping the chronic client. He contends that psychotherapy as practiced in CMHC's tends to avoid practical needs and leaves the client unprepared to face real life issues. Lamb advocates for "adaptive psychotherapy" which concentrates on real issues of

day-to-day survival. By concentrating on the client's daily activities a "closeness-distance" relationship is established with the client. Effective case management is then based on this relationship.

Lamb (1980) identifies case management functions as "part of the normal duties of the conscientious therapist,..." Proponents of the therapist/case manager agree with Lamb's logic that ..." only through significant therapeutic involvement does a case manager acquire the in-depth knowledge of the patient to adequately assess his needs and facilitate the process for meeting them."

Lamb strongly asserts, that the case manager should not be simply an "intermediate broker of services but the patient's primary therapist." He sees the functions of therapist and case manager as combined. He does not suggest adding case managers to the staff if therapists are not presently providing the case management functions. He believes that remiss therapists are not doing their complete job and should begin case management activities. According to Lamb, effective psychotherapy is reality oriented. The therapist is best prepared to understand the dynamics of the client's illness and is constantly informed about the client's daily life stresses. An additional advantage of the therapist/case manager role is an immediate feedback system to the client (Lamb, 1980). The case manager does not have to call a therapist to interpret or suggest a solution to a client generated problem. The two roles of the therapist and case manager are fulfilled by the same person.

Advocates of case management as a single professional role cite the time needed to fulfill the case management functions as prohibitive to the pursuit of therapy. Lamb (1980) proposes the use of paraprofessionals as 'legmen' for the case manager. The case manager knows the client and establishes the necessary activities. The paraprofessional would then actualize, with the client, the case management plan. Lamb believes more private therapists would pursue case management services for their clients, if the community supported paraprofessional-case manager was available to carry through the case management plan.

Marlowe, Marlowe, & Willetts (1983) explore the practical issues associated with mental health counselors being thrust into the role of case manager. They identify decreasing funds and increasing demands by the clients for service as the agents forcing the expansion of the role of the mental health counselor. This new role can place some counselors in a conflict situation. Many case management functions are administrative in scope. The trained therapist is generally not well versed or interested in administrative activities. Effective case management often times entails the manipulation of a reluctant community to accept and serve the chronic population. The requisite skills necessary for this manipulation are consistent with the administrative background rather than that of therapist. Marlowe et. al,. (1983) also suggests that the counselor may come in conflict with the employing agency. The client may need an advocate to support activities counter to the agency's plan or procedures. They believe it is "easier to advocate against an external entity than to advocate against one's own agency." Marlowe et. al. cannot discount the effectiveness of the therapist - case manager but caution the reader to expect difficulties in fulfilling both roles. They offer the following for consideration:

"Thus there are two intertwined issues for the mental health counselor who functions as a case manager; role identity and changes in professional activities. Effective case management requires a shift in professional identity from that of counselor to administrative clinician. In terms of activity, the case manager is no longer primarily a direct deliverer of services. Nor is the focus of concern solely psychological or emotional well being.

Whether or not the mental health counselor can function effectively as a case manager depends upon these same issues of professional identity and activities. If one's professional identity does not encompass a more administrative role, then effective functioning is improbable. Similarly, if the activities of case management are not personally and professionally rewarding, then such a professional change would be unwise. Hopefully, most mental health counselors called upon to perform case management functions can embrace the perspective state by Kraber (1982):

> 'When case managers do their jobs well, they are helping people to live more satisfactorily in their world. They can do that only by forming a positive involvement with the chronic psychiatric client and then helping them become more responsible to themselves and others. Is not that what a counselor-therapist accomplishes when deemed effective? Good case managers are good therapists (p. 665).'"

Kraber (1982) (cited in Marlowe et. al., 1983) suggests that perhaps the real issue is not whether the therapist can be an effective case manager but rather the case manager needs the skills and sensitivity of the therapist.

Summary

The literature tends to be biased toward supporting the notion that case management, if done properly, is too complicated, sophisticated and intense to be successfully done as a "part-time job." Certain researchers and organizations are only concerned that case management functions are fulfilled, by somebody. Most writers agree that effective case management is best performed by a well trained and respected professional case manager. As Kraber (1982) suggests: "Good case managers are good therapists (p. 665)."

Prepared by:

SED Network
January 1984

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INDIVIDUAL THERAPEUTIC AND EDUCATIONAL PROGRAM: UPDATE

The previous State Advisory Report (Jan., 1984) highlighted the three development phases of the ITEP. Phase I consisted of the development of a documentation system to record data and contain educational and therapeutic plans for each student. The resulting documentation system (in draft form) was distributed to four adolescent day treatment programs. The two in Pasco County were: Cooperative Adolescent Day Treatment Program in Dade City and Ridgewood Adolescent Day Treatment Program in New Port Richey. The two Pinellas programs were: Adolescent Day Treatment, Bryan Dairy and Intensive Adolescent Day Treatment Program, Safety Harbor. The staffs in these programs consisted of teachers and mental health professionals.

During the time period January 9th through 23, 1984 SED Network staff conducted training workshops with the day treatment staffs. The workshops included background of the ITEP development and method of implementation. There were several reasons for piloting the ITEP documentation system. These included: 1) Day Treatment has readily available teams of educators and mental health professionals; 2) the ITEP was designed to promote, multiprofessional development of treatment goals and objectives; 3) because of two agencies (School, Mental Health), combining records were problematic. (The ITEP was designed to ease this problem); 4) certain Day Treatment professionals participated in developing the ITEP system; 5) the Day Treatment staffs were interested in piloting the ITEP.

During the months after January, 1984 the Day Treatment staffs were monitored by SED Network staff and questions were addressed. Implementation Logs were also filled out by Day Treatment staffs as problems, questions or comments were made. In addition an evaluation survey was distributed to all staff involved. The evaluation instrument was designed to assess the viability and use of the ITEP system. A complete evaluation of the Day Treatment staff's feedback on the piloting of the ITEP has not been conducted since all of the data has not been collected.

Although the major thrust of the ITEP piloting was to 'iron out bugs' from the ITEP forms, the encouragement of mutual education/mental health planning for students was also assessed. Initial reactions to the piloting of the ITEP reveals that the forms themselves are not sufficient reason for the staffs to plan together services for children in their programs. Additional encouragement and support from programs supervisors and SED Network staff was needed to encourage the mutual planning effort. It is noteworthy that several of the day treatment programs were relatively new (less than one year in practice) and staff changes were common. Apparently the ITEP was viewed as helpful but somewhat cumbersome when other records were also required. Since the ITEP was being piloted, dual or duplicate forms required by the agencies were filled out by staff. Complete acceptance of the ITEP system would eliminate the need to keep several records. Further analysis and modification of the ITEP forms will be forthcoming as evaluation data is received and analyzed.

Phase II of the ITEP consists of the development and review of an Affective and Educational Goals and Objectives Handbook. Another comment from Day Treatment staff piloting the ITEP was that having a comprehensive handbook would have increased the usefulness of the ITEP forms. Two committees were established to

develop 1) Educational Goals and Objectives, and 2) Affective/Behavioral Goals and Objectives. The Educational committee consisted of teachers of both the emotionally handicapped (EH) and the severely emotionally disturbed (SED) as well as specific learning disabilities (SLD). Further assistance came from a representative of the Florida Diagnostic Learning and Resource System (FDLRS). This committee concluded its development of Educational Goals & Objectives in late May, 1984.

The Affective/Behavioral Goals & Objectives committee consisted of professionals from the Day Treatment programs and one private practioneer. This committee using a developmental hierarchy as its base has developed a sequence of behavioral and affective goals and objectives. The sequence, as with educational material acquisition, outlines the expected skills the student should have at a given developmental period. Treatment staff can, 1) use both the Educational & Behavioral Goals & Objectives as an evaluation instrument of the student's present level of functioning and 2) draw from the goals and objectives the logical course for the student to follow to develop missing skills or acquire new skills.

SED Network staff are soon to finalize the format of the completed goals and objectives and will be publishing a complete handbook for use with the ITEP documentation system.

Plans to introduce both the ITEP system and Handbook to all staffs working with SED students are being made. The anticipated time to present and implement the ITEP is early in the school year of 1984-85.

Phase III, the development of the Observation Instruments to assess the student's progress on achieving ITEP Goals & Objectives remains projected to late 1984 to begin development of these instruments.

SED DEFINITION COMMITTEE:
CONTINUED THINKING

The District V Case Review Committee (CRC) continues to be a forum for discussion of issues and ideas related to better defining the severely emotionally disturbed (SED) children's population. Formal and informal discussions among CRC members and other local professionals prompted SED Network staff to further evaluate the task of reconciling the apparent dichotomy between the educational and clinical definitions of severely disturbed youngsters. The second SED Network concept paper entitled: SED Definition: Multiagency Communication in the Continuum of Care, explores both the theoretical and actual functioning continuum of care models in Florida and in the District V region.

In essence, recent thinking on the definition issue has revised a statement of the original problem. In fact the two apparently incongruent definitions of severity of disturbance used by educators and mental health professionals are congruent if the orientation of their origins is taken into account. The clinical practioneer views the child more from a general gestalt aspect where functioning in school is but a part of the child's overall environment. Children dysfunctional at home, but not identified by educators as dysfunctional at school may well be clinically disturbed and require remediation. The child identified from the perspective of the educator may not appear overtly dysfunctional if they maintain the appearance of self-control and show some attempt at academic advancement.

From the perspective of the educator, a child is severely dysfunctional if their overt behaviors have a dilatorious effect on their academic development. The Florida classification of Severely Emotionally Disturbed is oriented to the proposition that the child's emotional dysfunction hampers academic and social development. The child, in another environment, such as home, may not be as dysfunctional since the demands placed on them at home may be less stringent or different.

The SED Definition Committee has concluded from the above, that the same child in different situations and viewed from different perspectives (i.e., education vs. clinical) may well be disturbed (or disturbing) in one or several of the situations but not necessarily all situations. The child is in no less need for help, but the artifical construct of definition should not be a barrier to that help. The conclusion reached by the Committee is that the two definitions of severity (i.e., education and clinical) are not at fault or do not need to be blended into one global definition. The issue is the communication between professionals from both sectors and the resulting understanding of the other professionals point of view.

The Florida continuum of care models for services to emotionally handicapped students describe a flow of the client from the least restrictive to most restrictive type services. As a client's dysfunction becomes more handicapping they move to the least restrictive placement or service designed to impact on the problem. Once the client is identified as having an emotional problem movement from one program to the next is based more on placement criteria than definition.

Criteria in the broad sense, is what services does the program offer and what behavioral descriptors are applied to the client that match the nature of the

program's services. The major question becomes: "Does the client meet the criteria of the service program?" The level of 'restrictiveness' is determined not by a definition, but by what intensity of dysfunction the client displays. This level meets a professionally established criteria. Above one point on the criteria a client would be considered severe, below the same point they are considered less severe. The point on the criteria is often times an arbitrary decision.

The SED Definition Committee is shifting its emphasis from SED definition to better understanding of the placement criteria of programs and the descriptive types of clients placed in those programs. Definitive plans to make formal data collection of criteria information have not been finalized to date. It is anticipated that by increasing awareness of program admission criteria and what types of clients are served in both residential and non-residential programs some of the former miscommunication blamed on the 'definitions' will be decreased.

In addition to gathering criteria data, the Case Review Committee (CRC) has begun reorganizing its procedures and practices. Reorganization includes rethinking the application and application review process. In conjunction with these changes, the Pinellas County Schools are adopting new District Procedures for referring students to the CRC. These District Procedures represent a major step forward in education's continued support and interest in the case review process.

New procedures, and continued collection of criteria data will promote communication among educators and mental health professionals. Communication is the key to better understanding of what an SED child is and how they may be best served.

SED DEFINITION: MULTIAGENCY COMMUNICATION IN THE CONTINUUM OF CARE

The SED Network has been charged with the task of resolving the issues surrounding the clarity and functionality of the definition of Severely Emotionally Disturbed (SED). Education and mental health professionals have debated the definition issue for decades. It may be presumptious to believe that the questions inherent to today's definition will be resolved in the near future. By examining current definitions the SED Network hopes to shed light on the definitional issue so that school and community based placements may be more smoothly determined.

Current sources of conflict in the issue of definition stem from the use of (1) clinically oriented and (2) educationally oriented definitions. In describing the populations of emotionally handicapped, severely emotionally disturbed and socially maladjusted, clinicians and educators run headlong into problems with differences in terminology, etiology, criteria and prognosis.

Mental health professionals rely on clinical definitions as listed by the Diagnostic and Statistical Manual of Mental Disorders - III (DSM-III). Public education professionals rely on definitions stated in PL 94-142, The Education for All Handicapped Children's Act of 1975. The definitions in DSM-III and PL 94-142 have been generated by two separate fields of endeavor, but in reality, are applied to a single population of children and adolescents frequently receiving services in both mental health and public school programs.

The definitions are oriented to and serve the professionals in the respective fields that created the definition. Professional judgment appears to be the ultimate factor that determines the label placed on a child. This judgment may be that of a single psychiatrist (mental health field) or a multidisciplinary staffing committee (public education). An element of professional "best guess" remains in making a diagnosis for placement purposes.

The apparent dichotomy between mental health and education definitions of SED may be merely a smoke screen generated by the individuals who diagnose. The salient issue for the SED Network is not establishing a new definition. The real issue then, is establishing effective communication among all professionals; whether they are mental health, education or child guidance service providers.

Communication and understanding of different professional jargon and diagnostic criteria will narrow the perceived gap between seemingly divergent approaches to defining children with emotional disorders. It is neither the mental health nor the educational definitions that are at fault. It is the lack of communication among those using them that creates the confusion. The current solution to the confusion is to blame the definitions for being inadequate or unreliable.

It is not the intent of the SED Network to determine the adequacy of the current definitions. Mental health and education personnel are guided by state rules and federal mandates that "cast the current definitions in stone." The task of the SED Network is to facilitate a process which will lead to the increased understanding of the state rules that have lead to the creation of the present definitions.

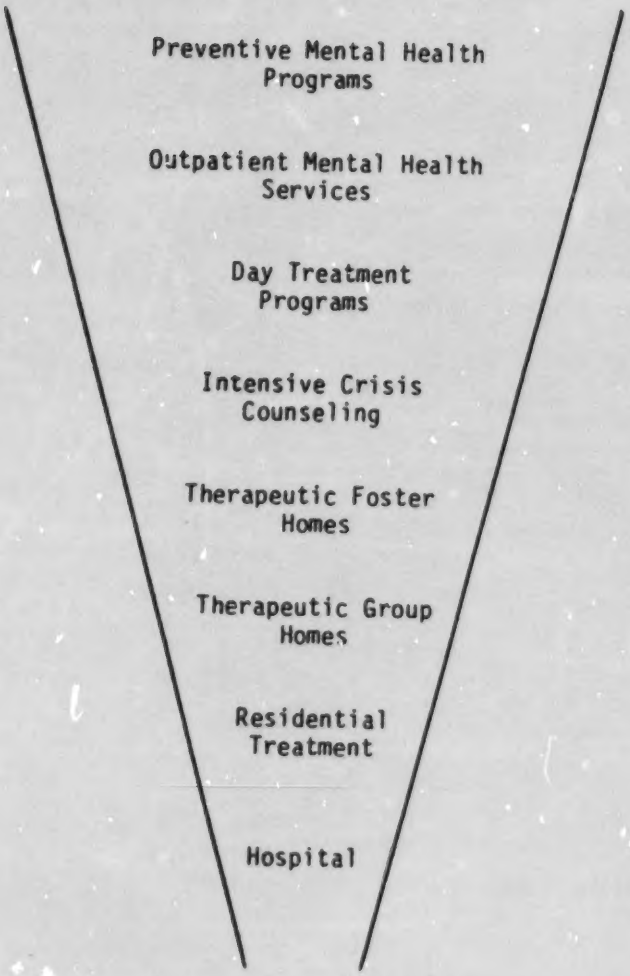
To facilitate this understanding it is proposed that the SED Network Definition Committee review existing criteria for entry into and exit from the specified environments in the continuum of care of service delivery options. Criteria must be developed for those service options shown in Figure 1, Floridas Continuum of Care for Children's Mental Health Services.

INSERT FIGURE 1

Figure 1 depicts the cascade of service delivery. The student enters the service delivery system along the continuum and is placed in the least restrictive environment to meet his individual needs. The top of the cascade represents the least restrictive type of services. As the student's dysfunction becomes more severe, or if they are initially evaluated as having a severe problem, they move to a more restrictive placement option.

FIGURE 1

FLORIDA'S CONTINUUM OF CARE FOR
CHILDREN'S MENTAL HEALTH SERVICES



To address the proposed recommendation of criteria for placement the SED Network must examine the continuum of care and develop specific criteria based on locally available children's mental health and educational services. The local continuum of care is shown in Figure 2.

INSERT FIGURE 2

Figure 3 represents the movement of a student from the regular classroom through the public school and mental health care systems. This movement is from least restrictive to most restrictive placements. Of particular interest are the placements of the student in:

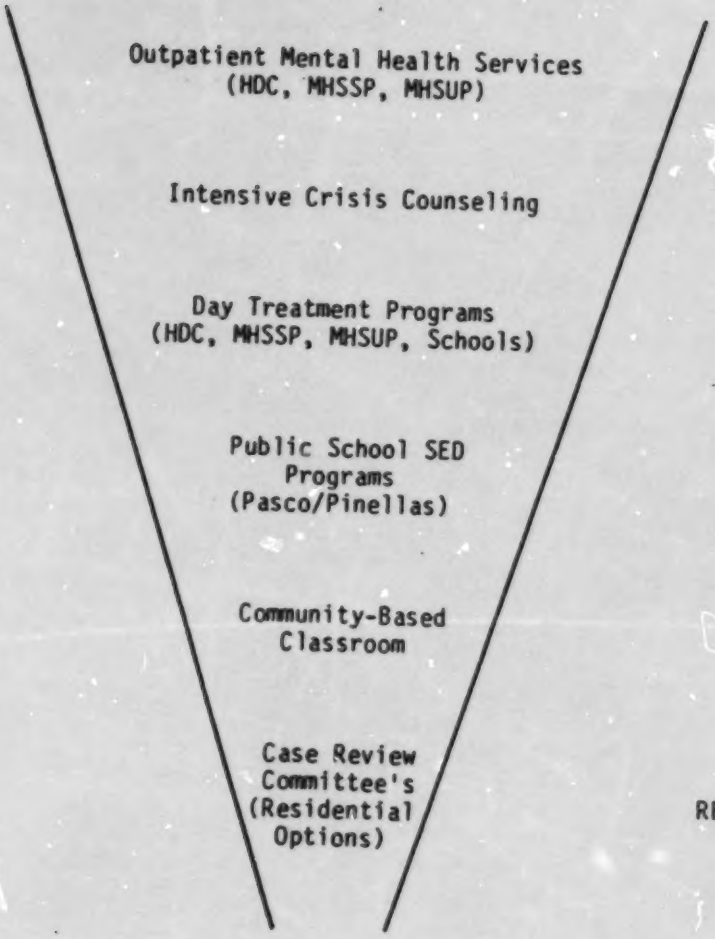
- Resource Emotionally Handicapped Classes
- Self-contained Emotionally Handicapped Classes
- Day Treatment Programs
- SED Centers

INSERT FIGURE 3

Each placement is more restrictive than the previous one and together they form the total educational continuum of care (cascade of services). The possible program exit options from these four programs are listed in the smaller boxes stemming from the four major program options.

FIGURE 2

PASCO/PINELLAS
CONTINUUM OF CARE FOR
CHILDREN'S MENTAL HEALTH SERVICES



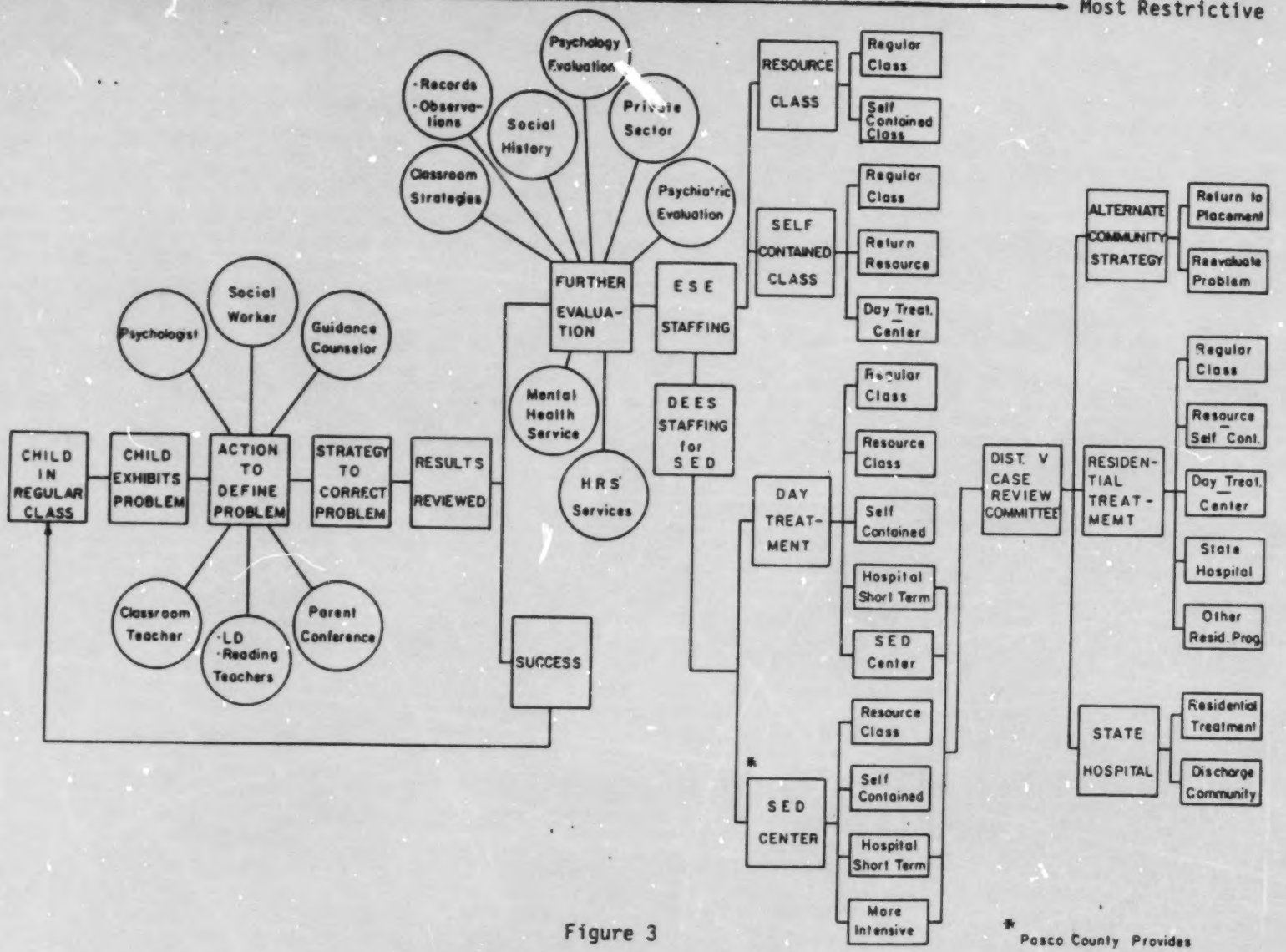


Figure 3

Public School Based
Service Delivery System
for SED/EH Students

Day Treatment and SED Center programs are examples of the school's most restrictive placements. From either of these placement options a student may be referred to the Case Review Committee for potential funding and placement in a residential treatment facility. At times state hospitals are the only viable placement options. School and mental health programs interact in the Case Review Committee to determine appropriate, highly restrictive placements.

The issue of definition is inherent in the placement of children in educational and mental health programs. The definition mandated by PL 94-142 is based on a student's increasing need for a restrictive program as the severity of his disability increases.

Movement from resource and/or self contained classes to SED Center or Day Treatment programs is based on the criteria of failure of the student in the less restrictive program. The SED definition established by PL 94-142 notes that

> "Evidence that a program in the lesser restrictive environment has not met the individual student's needs." (Florida State Board of Education Rule 6A-6.3016).

Failure, then, is an integral part of the definition or criteria for eligibility for placement in an SED Center or Day Treatment program.

Additional criteria are used to differentiate between the SED Center placed and Day Treatment placed student. When deciding whether a student enters a Day Treatment program, a more clinically oriented approach is taken. For example, consider two students who have failed in a less restrictive placement and need a more highly structured program. The child diagnosed as Conduct Disorder, Under Socialized, Aggressive, (DSM III-312.00) is most often placed in the SED Center program. The child labeled Conduct Disorder, Socialized, Non-aggressive (DSM III-312.21) is most often placed in Day Treatment Programs. The clinical description of these two children is significantly different. The prognosis for each is the deciding factor. The Day Treatment Program generally accepts the child with a more positive prognosis. Associated with the positive prognosis is the characteristic 'more willing to change' child. The typical Day Treatment student has a greater potential and capacity to make meaningful changes in emotional and behavioral control. This example highlights the functional use of both educational and clinical definitions used to place the child in the appropriate environment.

The need to blend the educational and mental health definitions is evident. Prognosis and severity of dysfunction are considered within the broader context of the SED classification. The two definitions of SED (clinical and educational) should not be considered mutually exclusive. They both describe the same child under different circumstances from different points of view. In addition, they may lead to a more comprehensive evaluation of the child's difficulties.

A review of Figure 4 shows that a child may enter the service system from a point in the community. For the purposes of the SED child, the final placement may be a school, mental health or residential program. Functionally, the two definitions of SED must mesh in a cohesive manner. Criteria for referral to education, mental health and/or residential placement is based ultimately on professional judgment, which considers etiology, prognosis and severity of disability. In reviewing Figures 3 and 4 one can verify the "funneling effect" that leads a child to a final, appropriate placement. This effect is also demonstrated in Figures 1 and 2.

INSERT FIGURE 4

In summary, a child may enter the service delivery system at any number of individual points, but at some time in the process is evaluated by educational and mental health definitions and criteria. More effective communication among professionals at all intake points will enhance placement decisions. In achieving effective communication the SED child will be placed in the least restrictive environment suited to meet his individual educational and mental health needs.

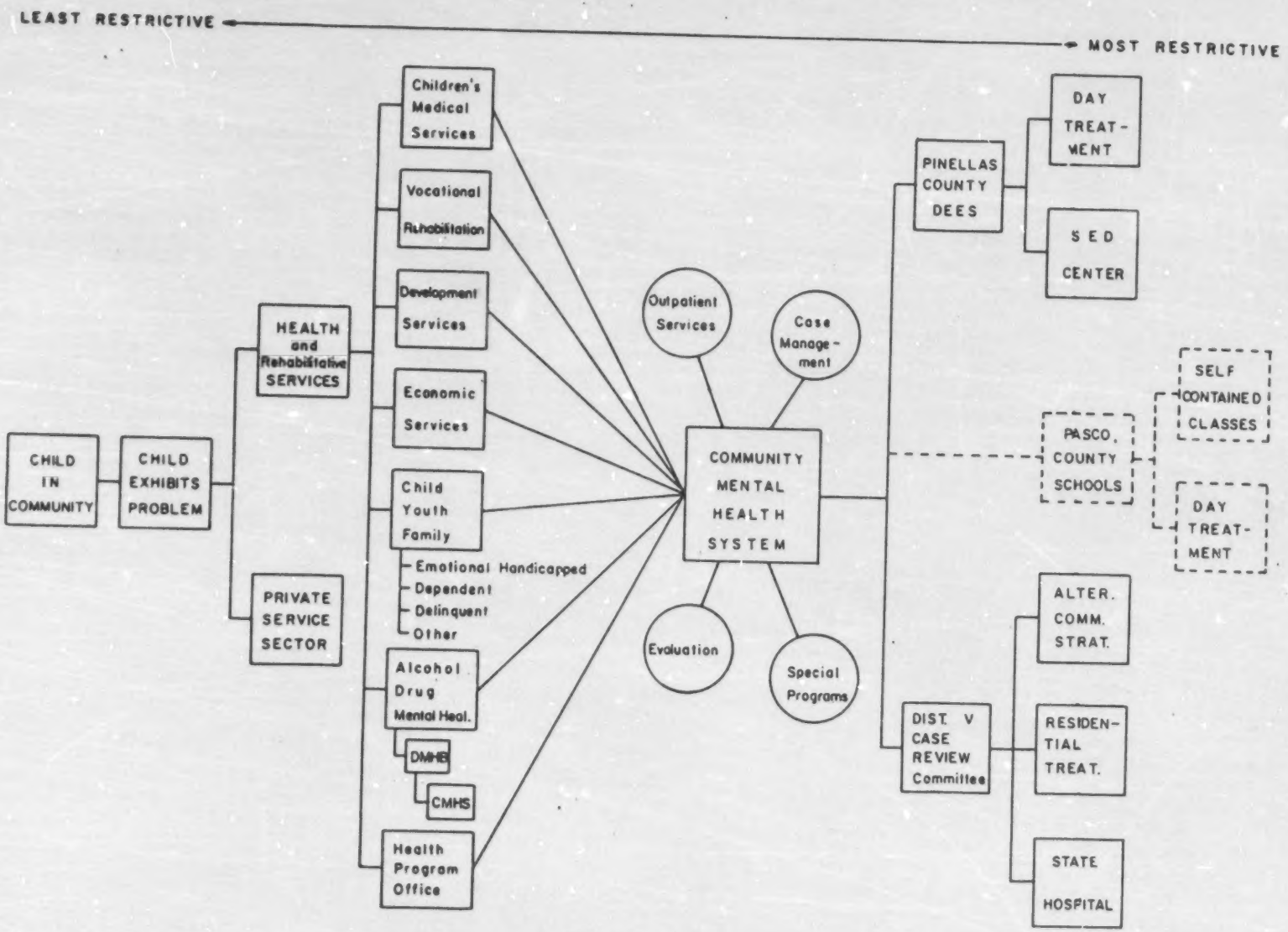


Figure 4

Community-Based Service Delivery System for SED/EH Students

Definition, therefore, may not be the issue. It may be more appropriate to consider: (1) criteria for placement, (2) etiology and/or prognosis, (3) professional judgment, (4) clinical interventions, and (5) educational remediation/instruction.

Each of these factors weighs more heavily in the placement decision making process than does the attempt to fit the individual child into a specific definitional construct.

February 1984

PINELLAS/PASCO SED PERSONNEL

PRELIMINARY SUMMARY OF INTERVIEW RESULTS

As a means to determine current issues, concerns and constraints facing direct service providers to the severely emotionally disturbed (SED) children and youth population, interview surveys were developed specific to each direct service category. In order to relate and record responses relevant to a specific service three independent surveys were developed. The areas surveyed included: 1) mental health professionals employed in public mental health facilities in Pinellas and Pasco County, 2) support staff working with SED students (i.e., guidance counselor, social worker, behavior specialist, assistant principal and psychologist) in Pinellas and Pasco County, and 3) teachers of SED students located in center programs, self-contained SED elementary classes and Day Treatment Programs both in Pinellas and Pasco County. Questions in the surveys were written in an "open-ended" style. This not only generated multiple responses and promoted a relaxed environment to conduct the survey, but also created a complicated statistical situation to analyse. Working in conjunction with the SED Network evaluation consultant, it was determined that the best approach to use in reporting these findings would be through the use of a simple content analysis summary of each survey group. Upon completion of these three summaries, conclusions and recommendations were developed. These recommendations will be presented to the SED Advisory Committee. Future planning involving direct service providers will include suggestions from these recommendations. Included in this brief report is a 1) purpose statement, 2) procedure statement, 3) demographic outline of respondents, 4) conclusions and 5) recommendations. A complete report of the findings is being developed in the form of a Technical Assistance Report.

SED TEACHER INTERVIEW SUMMARY
PASCO AND PINELLAS COUNTY SCHOOL SYSTEMS

Purpose

As stated in the 1983 SED Network Pilot Project Goal Number 3, Objective Number 8, the SED Network was charged with formally interviewing each classroom teacher presently serving severely emotionally disturbed students within the Pasco and Pinellas County School systems. The purpose of the interview procedure was to collect information which would enable SED Network staff to identify barriers, constraints, trends and issues of concern to direct service providers working with the SED population. The information collected during the individual interviews will allow SED Network staff to develop strategies and activities which will (1) enhance cooperation and understanding among agencies, (2) aid supervisors in planning, (3) identify barriers to program effectiveness, (4) assess education personnel needs and concerns, and (5) give education personnel a procedure for addressing the strengths and needs of the SED programs in their respective areas. It is hoped that the information provided in this summary will ultimately improve services to students.

Procedure

The individual interviews of education personnel serving severely emotionally disturbed (SED) students occurred during October, 1983 - April, 1984. A total of thirty- nine teachers were interviewed in the Pasco/Pinellas region. Thirty-six were located in Pinellas County and three were located in Pasco County.

The first section of the interview included demographic information. Specifically, teachers were asked questions concerning their educational background and experience. Information was gathered regarding: (1) location, (2) level of training, (3) certification, (4) number of years experience, (5) number of students per class, (6) age and (7) sex. See Table 1 for detailed data.

TABLE 1

Location	Number of Teachers	Age Range	Average Age	Sex	Level of Training	EH Certification	Years of Experience with SED						Number of Students Per Class	Age of Students	Number Served
							1	2	3	4	5	6			
Pinellas Safety Harbor Exceptional Student Center	Classroom 8 Other 5 13	24-48	29.8	2 M 11 F	8 Bach. 1 Bach. + 4 MA	6/8	10	2	0	1	0	0	4-14 Average= 7.5	6-21	72
Pinellas Richard L Sanders School	Classroom 12 Other 7 19	22-65	33.2	5 M 14 F	11 Bach. 2 Bach. + 4 MA 1 MA + 1 Rank III	12/12	4	2	4	4	3	2	5-10 Average= 7.6	6-21	125
Pinellas ADTP	4	29-31	29.7	2 M 2 F	3 BA 1 MA	4/4	2	0	0	1	1	0	8	12-17	32
Pasco	3	29-36	31.7	1 M 2 F	2 BA 1 MA	2/3							3-5 Average= 4	6-14	12
TOTAL	39			10 M 29 F											

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CONCLUSIONS:

The information collected during the individual interview of teachers serving SED students in the Pasco and Pinellas area revealed numerous concerns and issues. The following list of conclusions identifies the major areas highlighted as a result of this procedure.

1. Teachers are in need of information related to curricula/ materials that can be successfully used with SED students.

2. Teachers felt professionally unprepared to effectively include affective strategies and techniques in their classroom schedule.

3. Most teachers prefer a school-wide levels system for behavior management.

4. Most teachers chose the materials for their students based on what was currently available.

5. The majority of SED teachers stated that (1) ability to understand others, (2) sense of humor, (3) structure and organization, and (4) consistency of their classrooms were the most important personal characteristics they valued when working with SED students.

6. Teachers recommended that they receive training in (1) affective strategies and techniques, (2) SED/EH theory, (3) computers, (4) pre-vocational curriculum, (5) academics and (6) Aggression Control Techniques Training (ACT).

7. Teachers used phone calls and daily point cards to maintain contact with parents.

8. Teachers usually met with parents only when necessary.

9. Teachers understand the background of their students. However, prognosis is difficult to predict.

10. The majority of teachers believed that the strengths of their college programs were in the areas of technical knowledge and practical experience.

11. The majority of teachers felt that the areas of greatest need in their training programs were academic training and curriculum planning for SED students. Also mentioned was the need to be trained in affective strategies and techniques.

12. The majority of teachers stated that they planned on remaining in their current program for at least another year.

13. Most of the teachers were interested in sharing with and supporting their colleagues.

14. The majority of teachers viewed the SED Network as an additional resource for information, support, and training.

15. The majority of teachers felt very strongly that the faculty at each of their locations was the most positive aspect of their job. Teachers also expressed that working with SED students was very rewarding and their successes with their students was a high point of their job.

16. The majority of teachers preferred six students in their classroom. This preferred ratio included a classroom aide.

17. Overall the majority of teachers preferred a "mixed" group of students in their classrooms. "Mixed" group refers to one or more students from several categories.

18. Teachers were most concerned about (1) lack of county support, (2) limited behavior management training, (3) classification of students, and (4) receiving additional pay.

Recommendations

1. Teachers should be trained in the use of affective techniques and strategies.

2. Teachers should be trained on an on-going basis in the area of behavior management.

3. Teachers should be informed about a variety of materials that have successfully been used with SED students.

4. College/university training programs should emphasize the personal characteristics valued by teachers of SED students when training future teachers.

5. Teachers should receive training in the areas of academic curricula, Aggression Control Techniques Training (ACT), and the use of computers.

6. Teachers should emphasize parent contact as an integral part of the SED student's school program.

7. Teacher support and information sharing should be emphasized by administrators.

8. The SED Network should continue as a resource for SED teachers in an information, support, and training capacity.

9. The present student/teacher ratio should be lowered to one to six students with a paraprofessional.

10. Teachers should be "matched" as much as possible to the types of students they prefer working with.

11. Supervisors of SED teachers should be encouraged to (1) visit SED teachers on an ongoing basis, (2) involve SED teachers in planning of district priorities and program development, (3) prioritize the concerns emphasized by SED teachers and develop plans to implement them, and (4) provide SED teachers with the opportunity to discuss issues related to serving SED students.

SED NETWORK SCHOOL SYSTEM SUPPORT STAFF

INTERVIEW SURVEY

PURPOSE:

The purpose of this survey was to determine the extent of involvement of school support staff with the Severely Emotionally Disturbed (SED) Student population in both Pinellas and Pasco County. There are approximately 250 students labeled Severely Emotionally Disturbed in both counties. The interview was developed to identify not only the extent of Support Staff involvement with SED students, but also to record concerns, needs, and issues identified by School Support Staff. The data gathered from individual interviews supports trends, strengths and weaknesses specific to the population. An evaluation of the trends, strengths and weaknesses appear in the conclusion of this report.

PROCEDURE:

Fifteen (15) School Support Staff were individually interviewed. Both the School Board of Pinellas County and Pasco County District School Board were involved in the survey. Support Staff Personnel interviewed consisted of school psychologists, school social workers, behavior specialist, Guidance Counselors, Educational Specialists and Assistant Principals.

The following demographic information describes the Support Staff personnel interviewed. Each professional surveyed is involved directly with SED students in a school setting.

SUPPORT STAFF PERSONNEL

Psychologists	N = 2	Male = 0	Female = 2
Social Workers	N = 2	Male = 2	Female = 0
Guidance Counselors	N = 2	Male = 1	Female = 1
Educational Specialists	N = 2	Male = 1	Female = 1
ADTP Therapist	N = 2	Male = 2	Female = 0
Behavior Specialists	N = 3	Male = 1	Female = 2
Asst. Principals	N = 2	Male = 2	Female = 0

DEGREES

BA = 4
MA = 10
Ph.D. = 1

Years of Experience with SED Students = 3.0 years average
Years of Experience in regular education = 8.3 years average

CONCLUSIONS:

(1) Behavior management is viewed as the primary function of the SED Center. Vocational and prevocational curriculum were given the lowest priority.

(2) The behavior management program was cited as a major strength of the SED Center programs.

(3) Support staff identified a need for increased program development in the areas of vocational/career education and affective curriculum.

(4) Educational emphasis is shifting from a strictly academic program to a program emphasizing interpersonal relationship skills (affective curriculum) and the development of a vocational component.

(5) There is a need for increased parental involvement with the SED Center.

(6) Although specific individuals are in contact with as many as ten (10) community agencies there is no established person or procedure for inter-agency communication.

(7) Support staff depends primarily upon observatons of student behavior in an SED Center to determine appropriateness of placement.

(8) The use of a levels attainment system incorporated with the behavior modification curriculum is used to determine readiness for mainstreaming.

(9) The mainstreaming procedures appear to lack clarity and definition.

(10) The follow-up procedure within the SED Center appears to be on an individual, personal-interest basis.

(11) The majority of the support staff have a limited knowledge of mental health services.

(12) The success of mental health involvement with the SED Center staff and students was rated by the support staff as generally falling within the fair to poor range.

(13) Support staff indicated that workshops in (1) Development Play, (2) Aggression Control Technique, (3) Affective training, (4) Clinical therapies that would contribute to improved services to the SED population.

(14) There exists a need to clarify the use of component points to support staff.

(15) In reviewing the multitude of definition, descriptors, and behaviors used by support staff to identify the SED student, it is evident that no consistent definition of the SED student exists.

RECOMMENDATIONS:

(1) Explore the feasibility of expanding vocational opportunities offered in Pinellas & Pasco Counties to include Severely Emotionally Disturbed (SED) students.

(2) Develop or adopt a pre-vocational and vocational curriculum for SED Centers.

(3) Expand the use of affective curriculum within the SED Centers. Provide in-service training in affective skill development for Center staff.

(4) Aid SED Center staff in the development of a parent-involvement program.

(5) Develop, implement, monitor and evaluate a case management system for the SED school aged population.

(6) Develop procedures and techniques to assess appropriateness of placements of students in SED programs.

(7) Establish mainstreaming procedures to be used by center programs.

(8) An ongoing "follow-up" procedure needs to be defined that will allow for tracking of the SED students after he no longer is registered at a SED Center. This could be identified as a function of the childrens case management system.

(9) Plan and implement an in-service programs that would educate support staff and/or teachers about the:

(1) services provided by the Mental Health centers
(2) mental health referral procedures
(3) practices of Mental Health
(4) development use of the therapeutic treatment plan.

(10) Provide workshop opportunities for support staff personnel in:

(1) Development Play
(2) Aggression Control Techniques
(3) Clinical Techniques used in therapy for SED students
(4) Use of component points
(5) Vocational options and services

(11) Determine specific criteria or descriptors used to define the SED population.

SED NETWORK MENTAL HEALTH PROFESSIONAL INTERVIEW SURVEY

PURPOSE

The purpose of this survey was to determine the extent of involvement of mental health agencies with the Severely Emotionally Disturbed population of students in both Pinellas and Pasco County. There are approximately 250 students labeled Severely Emotionally Disturbed in both counties. The interview was developed to identify not only the extent of Mental Health involvement with SED students, but also to record concerns, needs and issues identified by the mental health professionals. The data gathered from the interview surveys supports trends, strengths and weaknesses of the Mental Health services in Pinellas and Pasco Counties specific to the SED population. An evaluation of the trends, strengths and weaknesses appear in the conclusion of this report.

PROCEDURE

Twenty-seven Mental Health professionals were individually interviewed. The Mental Health agencies involved in the survey were (1) Mental Health Services of South Pinellas County, Inc., (2) Mental Health Services of Upper Pinellas County, Inc., (3) The Human Development Center of Pasco.

The following demographic information describes the Mental Health professionals interviewed. Each professional was assigned by their agency to work with children and their families.

Mental Health Professionals: N = 27

Therapists: N = 25 Male 10 Female 15

Supervisors: N = 2 Male 0 Female 2

Degree: BS 4 MA 19 PhD. 4

Degree Type: Social Worker 23 Psychologist 3 Other 1

Licensed Therapists 9

Years of Experience: 6.4 years average

Agencies: Human Development Committee 8
MHSUP 11 MHSSP 8

CONCLUSIONS:

Data gathered from the survey of mental health professionals in Pinellas and Pasco Counties revealed numerous concerns and issues relevant to providing quality services for SED school-aged children. The following is a comprehensive representation of these needs and concerns.

1. Mental health therapists have only a minimal understanding of the public school's referral and placement procedure for children in exceptional education.

2. Mental health therapists have a need for an information and referral manual that would provide information about all exceptional educational programs in Pasco and Pinellas County School Systems.

3. Mental health therapists are not familiar with SED Center Prorams in Pinellas County.

4. In reviewing the multitude of definitions, descriptors, and behaviors used by mental health therapists to identify the SED student, it is evident that no consistent definition of the SED student exists.

5. There appears to be no consistent formal dismissal and follow-up procedures for the SED client involved in Mental Health Services.

6. There is no formal case management system for SED children and youth served through Mental Health Services.

7. Mental health therapists recognize the need to seek alternate forms of therapy for treatment of the SED client. Traditional therapies used n the treatment of most clients are often ineffective and inappropriate for the SED population.

8. Mental health therapists appear to be serving only a fraction of the SED population identified in Pinellas and Pasco Counties.

9. There is a lack of coordination of services between hospital programs for SED students and out-patient Mental Health Services.

10. Most mental health therapists expressed a willingness to attend in-service workshops dealing with:

    1) clinical approaches and therapies for the SED clients and
    2) specific SED programs provided by the public school system.

RECOMMENDATIONS:

1. Mental health therapists who have the potential to become involved with the SED student would benefit from information about the public school systems referral and placement procedure for exceptional students. This could be provided through in-service workshops or through an information and referral manual.

2. An information and referral manual needs to be developed that would briefly explain to professionals in education and mental health specific exceptional student education programs available in both Pinellas and Pasco County. This manual should include (1) a definition of the program, (2) criteria for eligibility, (3) contact person, and (4) referral procedure.

3. Mental health therapists need to be provided with in-service training that would familarize these professionals with the SED Center concept.

4. A definition for SED needs to be developed that is acceptable by both the mental health profession and the education profession.

5. A formal dismissal and follow-up procedure needs to be developed for use with SED school-aged children involved with Mental Health Services.

6. A case management system for SED children and youth served through Mental Health Services needs to be developed.

7. Alternate forms of therapy to be used with the SED population needs to be explored and these options made available to mental health professionals.

8. In order to serve a greater number of the SED students, Mental Health Services need to be available at each center. This could be achieved through the contracting of full-time mental health professionals at each center. (A cooperative agreement between Mental Health Services and the local school board would need to be developed as a means of providing a therapeutic component in the SED Center.)

9. Hospital Services for the SED population need to establish specific procedures for:

   1) communicating with Mental Health Services specifically

      a) discharging of patients
      b) release of patient information to Mental Health Service

SED NETWORK VOCATIONAL SURVEY

STATEMENT OF PROBLEM

The 1984 SED Network Pasco/Pinellas Multiagency Network for Severely Emotionally Disturbed (SED) Students Pilot project states: the network staff will "expand the availability of vocational programs to SED students in the Pinellas/Pasco Region" (p.87 and 88, Project Plan).

PURPOSE

The project staff, under the direction of the SED Advisory Committee, will investigate and determine career education/vocational training options available to SED students. Programs reviewed will include: 1) School Board of Pinellas County, 2) Pasco County District School Board, 3) Junior Colleges in Pinellas and Pasco Counties, 4) Private vocational technical centers, 5) Health and Rehabilitation Services, District Five. From this investigation a list of issues related to barriers and constraints preventing SED students from receiving local vocational services will be developed. These issues will be employed in generating staff recommendations for the improvement and expansion of career/vocational services to SED Students.

RATIONALE

When faced with the severity and complexity of the behavior disordered adolescent on a daily basis, parents and educators have often superceded career/vocational considerations with programs to remediate specific behavior disorders while providing basic foundations in academic areas.

However, in planning for job success, vocational programs for the handicapped include training in work habits, attitudes, as well as personal-social skills (Meers, 1980). Furthermore, the Vocational Education Admendment of 1976 includes training in the personal-social skills areas as a component of the definition of Vocational Instruction. These areas of personal-social skills are of primary importance to the emotionally disturbed students both in vocational training and future successful community adjustment.

In many school districts the emotionally disturbed student has often dropped out of school by age 16. Frequently their behaviors have excluded them due to placement in residential psychiatric or juvenile detention facilities. Estimates of the prevalence of behavior disorders vary from about .5% of the school population to 20% or more (Kauffman, 1981). These estimates combined with 44.6% increase in juvenile delinquency among adolescents (U.S. Bureau of Census, 1978) support the need for the developments of alternative educational programs. It becomes increasingly apparent that traditional educational curriculum and behavior management procedures are not effective in providing a positive educational experiences in preparing the emotionally disturbed adolescent for successful post-school adjustment (Webster, 1981).

DESCRIPTION OF STUDY

Currently in the Pasco/Pinellas Region a number of vocational programs are in operation. These include: 1) Programs under School Board of Pinellas County,

2) Programs under Pasco District School Board, 3) Junior College, 4) Private vocational technical centers, and 5) Health and Rehabilitative Services V (HRS).

Data on specific programs in each area was collected through 1) site visitations, 2) personnel interviews, and 3) a program information survey. A frequency count of responses was recorded. Data gathered through the survey was used in the formation of conclusions and recommendations.

SUMMARY OF PROGRAMS

The Pasco/Pinellas Region appears to offer a wide variety of career/vocational training opportunities in both the public and private sectors. Most programs offer evaluation, treatment and placement services.

Vocational Rehabilitation services facilitate and compliments the vocational program offered to handicapped students in this region. It is the expressed intentions of both private and public sectors paired with the vocational/rehabilitative services to work toward improving the quality of Vocational programs for all young people.

SURVEY RESULTS

Demographic Information

The sample interviewed included: ten (10) vocational rehabilitative counselors from State of Florida HRS District V, six (6) public vocational education teachers, three (3) public school principals, and four (4) private career/vocational program directors. For purposes of more accurate reporting, these responses will be grouped into Vocational Rehabilitative personnel (10) and Vocational Education professionals (13).

CONCLUSIONS

1. There exists a need for further pre-vocational training for the SED student in the Affective and Cognitive areas with respect to successful vocational functioning.

2. There exists a need for a pre-vocation curriculum for the SED student that more closely supports the goals and objectives of local vo-tech programs.

3. Present vocational programs in secondary SED centers (home economics, agriculture and industrial arts) could better prepare students for post school vo-tech training if their goals and objectives more closely paralleled those of the vo-tech programs.

4. There is an apparent lack of communication among vocational educators, SED personnel and vocational rehabilitation personnel.

5. Among educators there is a need for increased awareness of vocational opportunities in the Pinellas/Pasco Region.

6. Very few SED secondary students have been provided the opportunity for adequate vocational assessment.

7. In Pinellas County few SED students have utilized the Career Assessment Center.

8. There is a need for increased in-service training available to vocational personnel in the following areas: 1) characteristics of SED Students, 2) management of SED Students, 3) programs available to SED Students.

9. There appears to be little community support for SED programs.

10. Vocational and SED personnel need to become more familiar with procedures concerning staffing, referral and evaluation for vocational placement.

11. Poor student attendance was noted as one of the major causes of students not completing vocational programs.

12. Currently there is only one SED student enrolled in the public vo-tech centers in Pinellas County.

13. Traditionally the Adolescent Day Treatment Programs have not particpated in vocational assessment or training.

14. Private vocational training centers report long (i.e., over 1 year) waiting list in most programs.

RECOMMENDATIONS

The following recommendations are based upon interviews, survey results and conclusions drawn from those results:

1. Development of a pre-vocational curriculum for SED students in the areas of Affective Education as it pertains to successful vocational functioning.

2. Development of a pre-vocational curriculum for SED students in the area of cognition as it pertains to successful vocational functioning.

3. Development of a pre-vocational curriculum that reflects the communities current needs and resources.

4. In-service training for secondary SED personnel in the areas of: 1) current local voc/tech programs, 2) availability of vocational assessment, 3) referral and staffing procedures for vocational placement, 5) criteria for placement in vocational programs.

5. The SED Network will facilitate a council to increase communication. This council will include: 1) SED personnel, 2) vocational rehabilitation personnel, 3) vocational assessment personnel, 4) job placement personnel, 5) public and private vo-tech personnel, 6) private industry representatives.

6. The SED Network will develop and disseminate a vocational resource guide that includes the following: 1) contact personnel address and telephone number, 2) brief program description, 3) criteria for eligibility.

7. Selection of a standardized vocational aptitude inventory to be administered to SED students during the final year of elementary school or the first year of secondary school

8. All secondary SED students in Pinellas County will be provided the opportunity to utilize the resources offered by the Career Assessment Center.

9. In Pasco County the SED students will be provided the opportunity to participate in the district's Vocational Assessment Program.

10. A workshop to provide Vocational Rehabilitation personnel, Vocational Technical personnel and other related personnel, necessary information on the characteristics, management and programs available to SED students will be developed.

11. An intensive investigation into creative methods of increasing student attendance should be initiated. This investigation should include the research and review of current literature supplemented by on sight visits and interviews.

12. An advocacy group for vocational education of SED students needs to be developed.

13. Steps should be taken to increase contractual funding to private training programs in order to reduce lengthy client waiting lists.

INSERVICE TRAINING AND INFORMATION DISSEMINATION ACTIVITIES

SUMMARY REPORT

Introduction

The SED Network has as its purpose the development of quality services in the education, mental health treatment, and residential care of severely emotionally disturbed (SED) students. Four major goals are addressed: (1) provision of a complete array of education, mental health and residential services, (2) improvement of the quality of existing services, (3) participation in continuous multiagency planning, implementation and evaluation of services, and (4) dissemination of exemplary policies and procedures. Included in these goals are (1) the development, implementation, and evaluation of inservice training for personnel serving severely emotionally disturbed students and (2) dissemination of information related to SED Network activities. This summary report will address three major inservice training and dissemination activities. These activities include (1) presentations, conference sessions, and workshops provided by SED Network staff and consultants, (2) the planning and implementation of a regional conference co-sponsored by the SED Network, and (3) the public relations materials submitted by SED Network staff including newspaper and newsletter articles and community awareness efforts. In addition, this summary report will address future planning in each of the three areas listed.

Activity Number 1 - Inservice Training

Inservice training activities presented by SED Network staff generally fall into two main categories. These two categories are (1) community awareness of SED Network activities, and (2) training in quality and exemplary techniques and strategies related to the services provided for severely emotionally disturbed (SED) students.

The first category - community awareness of SED Network activities - includes presentations, conference sessions, and workshops that provide information about current projects and activities of the SED Network. These include (1) an explanation of SED Network goals and objectives, and (2) the development of the Individualized Therapeutic Educational Program (ITEP).

The second category, that of training, addresses the need for inservice training in quality and exemplary techniques and strategies. SED Network staff and consultants provide training for professionals serving SED students. These presentations include topics on (1) use of the ITEP, (2) use of video tape activities, and (3) preventative strategies for use in the SED classroom.

Both community awareness activities and training activities are evaluated using a standard evaluation form. In addition, participant logs are completed for record keeping purposes.

A complete list of training and community awareness activities is listed below. A sample evaluation form is attached.

July, 1983-June, 1984
SED Network
Community Awareness and Inservice Training Activities

1. August 18, 1983
   Florida Council for Community Mental Health -Tampa, Florida
   1983 State Conference
   Networking: Two Pilot Programs for SED Children

   Dale Braiman, Project Director, SED/NET
   Shawn Roach, Juvenile Welfare Board of Pinellas County
   Lee Sherry, Project Manager, SED Network
   Mike Tomalesky, Program Coordinator, SED Network

2. August 23, 1983
FDLRS Gulfcoast Educational Conference - Pinellas County
Multiagency Network for SED Students: Florida's Pilot Project

Lee Sherry, Project Manager, SED Network
Mike Tomalesky, Program Coordinator, SED Network

3. August 24, 1983
EH/SED Inservice Day - Pinellas County
Multiagency Network for SED Students: Florida's Pilot Project

Maureen Gale, Training & Resource Liaison, SED Network
Carol Makin, Training & Resource Liaison, SED Network

4. October 14-16, 1983
Florida Federation Council for Exceptional Children -
Miami Beach, Florida
1983 State Conference

a) Multiagency Network for SED Students: Florida's Pilot Project

Lee Sherry, Project Manager, SED Network
Mike Tomalesky, Program Coordinator, SED Network
Carol Makin, Training & Resource Liaison, SED Network

b) Multiagency Development of an ITEP for SED Students

Susan Avery, EH/SED Program Supervisor, Pinellas County
Anne Benedini, EH Program Supervisor, Pasco County
Michael Fitzgerald, Social Worker, Pinellas County
Karen Kuehn, Staffing Specialist, Pasco County

c) Use of Video Tape Techniques in the Classroom with SED Students

Dave Riordan, SED Classroom Teacher, Pinellas County

d) Prevention and Early Intervention of Emotional Handicaps: A Relationship Focused Approach

Steve Meckel, Therapeutic Preschool Classroom Teacher, Pinellas County

5. October 28, 1983
   Richard L. Sanders School

   a) Preventive Strategies for Use in the SED Classroom - Elementary/Middle School

      Maureen Gale, Training & Resource Liaison, SED Network
      Karen Amundrud, Behavior Specialist, Pinellas County

   b) Preventive Strategies for Use in the SED Classroom - High School

      Carol Makin, Training & Resource Liaison, SED Network
      Dennis Harrison, Behavior Specialist, Pinellas County

6. November 2,1983
   Florida Association of School Psychologists - Tampa, Florida
   Overview of Individualized Therapeutic Educational Program (ITEP)

      Mike Tomalesky, Program Coordinator, SED Network
      Lee Sherry, Project Manager, SED Network

7. January 20, 1984
   SED Personnel - Pasco County
   Use of the Individual Therapeutic Educational Program (ITEP)

      Carol Makin, Training & Resource Liaison, SED Network
      Michael Tomalesky, Program Coordinator, SED Network

8. January 23, 1984
   SED Personnel - Pinellas County
   Use of the Individual Therapeutic Educational Program (ITEP)

      Maureen Gale, Training & Resource Liaison, SED Network
      Michael Tomalesky, Program Coordinator, SED Network

9. March 2, 1984
Florida Federation Council for Exceptional Children
1984 Leadership Training Conference - Panama City, Florida
Multiagency Network for SED Students: Florida's Pilot Project

Lee Sherry, Project Manager, SED Network
Mike Tomalesky, Program Coordinator, SED Network
Dale Braiman, Project Director, SED/NET
DeDe Wells, State Consultant, EH, BEES

10. April 24, 1984
Council for Exceptional Children
62nd Annual Convention
Washington, D.C.
Multiagency Network for SED Students: Florida's Pilot Project

Lee Sherry, Project Manager, SED Network
Michael Tomalesky, Program Coordinator, SED Network
Susan Avery, EH/SED Program Supervisor, Pinellas County
Shawn Roach, Juvenile Welfare Board, Pinellas County
Dale Braiman, Project Director, SED/NET
Carol Anne Redditt, SED/NET

SED NETWORK

Session Title:_____ Date:_____

Session Location:_____ Position:_____

We need your reactions and constructive criticism in order to make improvements in sessions presented by the Pinellas/Pasco SED Network. Please take a moment and rate the session in terms of its helpfulness to you in performing your work.

DIRECTIONS

Please place in the response box the number you believe represents most closely your perceptions of the session for each item below. Use the following rating scale.

1 - Strongly Agree; 2 - Agree; 3 - Neutral; 4 - Disagree; 5 - Strongly Disagree

☐ 1. The session was well organized and showed good planning.

Comments:

☐ 2. The purposes of the session were stated clearly.

Comments:

☐ 3. The information should be helpful in improving programs and services for severely emotionally disturbed students.

Comments:

☐ 4. Questions were answered satisfactorily and directly.

Comments:

☐ 5. Time devoted to topics was adequate to achieve understanding.

Comments:

☐ 6. The visual and printed aids were helpful in understanding the topics.

Comments:

☐ 7. Overall, the session was informative and worthwhile.

Comments:

(Please respond to questions on back.)

THE MOST VALUABLE PART(S) OF THIS SESSION WAS:

THE LEAST VALUABLE PART(S) OF THIS SESSION WAS:

RECOMMENDATIONS FOR IMPROVEMENT (CONTENT, MATERIALS, PROCESSES, FACILITIES, ETC.):

SUGGESTIONS FOR IMPROVING SERVICES TO SED STUDENTS:

Activity Number 2 - Meet the Leaders: 1984 Regional Conference for Emotionally Handicapped and Severely Emotionally Disturbed Children/Youth

The SED Network was one of five co-sponsors of the first regional conference for personnel serving emotionally handicapped and severely emotionally disturbed. Other sponsors were (1) Florida Diagnostic and Learning Resource System (FDLRS) - Gulfcoast Center, (2) Hillsborough County Schools, (3) Juvenile Welfare Board of Pinellas County, and (4) School Board of Pinellas County. The conference, held on February 18, 1984 in Pinellas Park, Florida, was the result of five months of multiagency planning. Funding and implementation could not have been accomplished without the commitment of all five sponsors. Attendance at the conference was approximately 200. Six speakers presented both morning and afternoon sessions. The evaluations of the sessions were positive and the participants encouraged the planning committee to hold the conference again in 1985. A conference program follows this description.

1984 CONFERENCE PLANNING COMMITTEE

DR. SUSAN AVERY, Supervisor,
Program for Emotionally Handicapped and
Severely Emotionally Disturbed Students,
School Board of Pinellas County

MS. KAY CAMPBELL, Resource Teacher,
Florida Diagnostic and
Learning Resource System/Gulfcoast

MS. MAUREEN GALE, Training and Resource Liaison
Pasco/Pinellas SED Network

DR. JACK R. LAMB, Assistant Superintendent
Department of Education for Exceptional Students
School Board of Pinellas County

MS. SUZAN MULLINS, Resource Teacher
Program for Emotionally Handicapped
and Severely Emotionally Disturbed Students,
School Board of Pinellas County

DR. LEE SHERRY, Project Manager,
Pasco/Pinellas SED Network

MS. DEBBIE SIMPSON, Supervisor,
Florida Diagnostic and
Learning Resource System/Gulfcoast

IN APPRECIATION

The Conference Planning Committee extends sincere appreciation to:

Morning Star School of Pinellas Park
and Sacred Heart Catholic Church ..... Facilities.

Vision Cable, Inc. ..... Video Equipment

DEC Chapter #176 ..... Refreshments

Suncoast CCBD ..... Restaurant Guide

The Meet the Leaders Conference is a result of
the cooperative efforts of many agencies.
Without their combined energy and enthusiasm,
this Conference would not have been possible.

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MEET THE LEADERS:

1984 REGIONAL CONFERENCE FOR EMOTIONALLY HANDICAPPED AND SEVERELY EMOTIONALLY DISTURBED CHILDREN/YOUTH

February 18, 1984 **Pinellas Park, Florida**

Florida Diagnostic and Learning Resource System - Gulfcoast Center

Hillsborough County Schools

Juvenile Welfare Board of Pinellas County

Pasco/Pinellas SED Network

School Board of Pinellas County

CONFERENCE SCHEDULE

8:15-8:40 a.m. ..... Registration Confirmation and Refreshments

8:45-9:50 a.m. ..... Opening Session

Presiding ..... Dr. Susan Avery, Supervisor
Programs for Emotionally Handicapped and Severely Emotionally Disturbed,
School Board of Pinellas County
Clearwater, Florida

Welcome ..... John Blank, Associate Superintendent,
School Board of Pinellas County
Clearwater, Florida

Special Guest ..... Ms. Diana Wells, Consultant
Program for the Emotionally Handicapped
Bureau of Education for Exceptional Students
Tallahassee, Florida

Keynote Address ..... "Pains and Joys of Helping Children"
Dr. Nicholas Long
Professor of Special Education
American University
Washington, D.C.

10:00-11:30 a.m. ..... Concurrent Sessions*
(Session I)

*Participants attend session indicated on Registration Confirmation Form enclosed in your Registration Packet

TITLE	ROOM
Directions of the Profession Dr. Lyndal Bullock	Dining Room
Hitting and Hugging: Social Problem Solving for Elementary School Aged Children Dr. Ellis Gesten	Room 21
Mission Impossible! Progamming for Severely Emotionally Disturbed Students Within a Public School System Dr. Ron LaNeve	Room 22
The Passive Aggressive Child Dr. Nicholas Long	O.T.H.E.R.S. Morning Star Hall

The Many Faces of Aggression: How Can We Cope with Children's Aggressive Behavior? Dr. William Morse	Room 28
Where is the Mind? Dr. William Rhodes	Room 27

11:30-1:00 p.m. ..... LUNCH

For your convenience a map indicating local restaurants has been included with your registration information.

1:00-2:30 p.m. ..... Concurrent Sessions*
(Session II)

*Sessions to be conducted as listed above. Titles, speakers, and locations of sessions remain the same. Participants attend session indicated on Registration Confirmation Form enclosed in your Registration Packet.

2:40-4:00 p.m. ..... Panel Discussion

O.T.H.E.R.S. Morning Star Hall

STRUGGLES AND ISSUES FACING EH AND SED IN THE '80's

Panel Moderator
Dr. Lee Sherry, Project Manager
Pasco/Pinellas SED Network

PANEL PARTICIPANTS

Mr. Craig Anderson
Principal
Richard L. Sanders School
School Board of Pinellas County

Dr. Lyndal Bullock
Professor
College of Education
North Texas State University

Ms. Pat Gehant
Director of Planning
District Mental Health Board V

Dr. Nicholas Long
Professor
Division of Special Education
American University

Dr. August Mauser
Chairman
Dept. of Special Education
University of South Florida

Mr. Michael Meredith
Behavior Specialist
Pasco County Schools

Ms. Oma Pantridge
Director
Exceptional Student Education
Pasco County Schools

Ms. Mary M. Rasor
EH Teacher
Largo Senior High School
Pinellas County Schools

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Activity Number 3 - Public Relations

Public relations efforts of SED Network staff include preparing and submitting press releases, newsletter articles and staff development information to Pasco and Pinellas County information sources. The contact persons for each of these sources is listed below:

Publication	Address
FDLRS Newsletter Claudia Graves Resource Teacher	Pony - Pinellas County
EH Newsletter Susan Avery, Supervisor Programs for EH/SED	Pony - Pinellas County
Medfield Center News Joyce Connolly, Editor	12891 Seminole Blvd. Largo, Fl. 33544
Training Post Juvenile Welfare Board R.J. Dooley	4140 - 49th St. N. St. Petersburg, Fl. 33709
YSAC Reporter Elithia Stanfield, Editor Juvenile Welfare Board	4140 - 49th St. N. St. Petersburg, Fl. 33709
TOPICS Communications Department Georgiana Anderson Public Information Specialist	Pony - Pinellas County
School Board Newsletter Pasco County School Board Ralph Martin, Supervisor Personnel, Pasco School Board Office	7227 U.S. Highway 41 Land 'O Lakes, Fl. 33539

In addition, SED Network staff have published the Report to the State of Florida SED Advisory Board through the Educational Resources Information Center (ERIC, Reston, Virginia). The material describes the activities of the SED Network during 1983. The information is abstracted for Resources in Education and Exceptional Child Education Resources.

The specific articles submitted to newsletters and newspapers in Pasco and Pinellas Counties, their dates of publication, and titles are listed below.

1. SED Network Introduction, TOPICS, August 22, 1983
2. SED Network Introduction, EH News, September, 1983
3. SED Network Introduction, FDLRS Newsletter, September, 1983
4. SED Network Introduction, Broadcasting Industry Council News, September, 1983
5. Meet the Leaders Conference, Training Post, November, 1983
6. SED Network Introduction, YSAC Reporter, December, 1983
7. Educators, Mental Health Officials Join Forces to Aid Disturbed Youth, St. Petersburg Times, December 19, 1983
8. Meet the Leaders Conference, TOPICS, January 16, 1984
9. Meet the Leaders Conference, FDLRS Newsletter, January, 1984
10. Community Based Program, FDLRS Newsletter, January, 1984
11. South Pinellas Adolescent Day Treatment Program, YSAC Reporter March, 1984
12. Individualized Therapeutic Educational Program (ITEP), FDLRS Newsletter, April, 1984

Although it is not possible to submit copies of the articles as published, samples of the information submitted for publication are included. The sample topics are (1) SED Network Introduction, (2) Community Based Classroom Program, and (3) Meet the Leaders Conference.

MULTIAGENCY NETWORK FOR SEVERELY EMOTIONALLY DISTURBED STUDENTS (SED NETWORK)

The Multiagency Network for Severely Emotionally Disturbed Students (SED Network) is the Urban Pilot Project serving Pinellas and Pasco Counties. The Project is funded through the Florida Department of Education, Bureau for the Education of Exceptional Students. The purpose of the SED Network is to develop efficiency and quality in education, mental health treatment, and residential services for severely emotionally disturbed (SED) students. The project addresses four major goals:

(1) provide a complete array of education, mental health, and residential services.

(2) improve the quality of existing services.

(3) participate in continuous multiagency planning, implementation and evaluation of services.

(4) diffuse exemplary policies and procedures.

As a model project for the State of Florida the SED Network is examining overlapping of service delivery, identifying service gaps, and establishing a means to assure services to students, families, and related agencies. Project activities include the development and implementation of (1) multiagency community awareness, (2) educational and therapeutic strategies and best practices, (3) a case management system for SED children, (4) educational and mental health development activities, and (5) a comprehensive evaluation system.

To accomplish these goals Project staff are working to facilitate communication among all planning and funding agencies. Specifically, coordinated efforts are shaping the planning process of the District Mental Health Board V, Inc., Health and Rehabilitative Services District V, the Juvenile Welfare Board and the Pinellas and Pasco County School Boards. In addition to these agencies, efforts are being made to involve all other direct service provider agencies.

A multiagency Advisory Committee, with representatives from 17 local education, mental health and other human service agencies monitors SED Network activities. This group also serves as a forum to explore policy issues and advocate for the educational and mental health needs of severely emotionally disturbed children and youth.

Network staff are working throughout HRS District V with all direct service personnel who serve SED children/adolescents. Working with teachers, mental health professionals, administrators and other support staff, Network staff are providing additional assistance in the coordination of services. As facilitators for multiagency cooperation initial Project results suggest that multiple agency service coordination is rapidly becoming a reality.

SED Network Staff

Project Manager - Dr. Lee Sherry
Program Coordinator - Michael Tomalesky
Training and Resource Liaisons - Maureen Gale and Carol Makin

SED Network Address

4960 - 78th Avenue North
Pinellas Park, Florida 33565

SED Network Telephone Number

(813) 541-4440

COMMUNITY-BASED PROGRAM

The Community-Based Class Program (CBC), an extension of Richard L. Sanders School, will be operational January 2, 1984. This program will be located at Enoch D. Davis Center, 1111 - 18th Avenue South, St. Petersburg.

The Community-Based Class Program is designed to provide an alternative therapeutic and educational program for Severely Emotionally Disturbed adolescents who are presently unsuccessful in the SED Center. The major emphasis of the program is on remediation of the dysfunctional behaviors which have prevented the students' success in the classroom.

The CBC Program's classroom teacher, Judy Moore, will be responsible for developing, implementing, and monitoring an Individualized Therapeutic and Educational Program (ITEP) for each student. Based upon the behaviors identified through the referral process, the teacher in conjunction with mental health staff also employed in the program will establish specific target goals and objectives. Ms. Moore's extensive experience both as an instructor at the University of South Florida and as a special education classroom teacher in Pinellas County has prepared her to meet the special needs of the student's participating in this program.

The Community-Based Class Program will be a therapeutic milieu through the use of an affective curriculum and daily individual and/or group therapy. Another vital component of the program will be the involvement of the student's family through family therapy, parenting skills development and ongoing communication.

The Community-Based Classroom Program has been developed through the cooperative efforts of the following community agencies:

1. Department of Education for Exceptional Students, School Board of Pinellas County
2. District Mental Health Board V, Inc.
3. Eckerd Foundation
4. HRS District V
5. Juvenile Welfare Board
6. Mental Health Services of South Pinellas, Inc. Child Guidance Center
7. Richard L. Sanders School
8. SED Network
9. 6th Judicial Circuit Court

Further information about this program may be obtained from: the SED Network, EH/SED Department, School Board of Pinellas County, and Mental Health Services of South Pinellas - Child Guidance Center.

ANNOUNCEMENT FOR TOPICS

TITLE: Meet the Leaders: 1984 Regional Conference for Emotionally Handicapped and Severely Disturbed Children/Youth

BRIEF DESCRIPTION: Nationally recognized leaders in the field of education and treatment of emotionally disturbed children will present state-of-the-art approaches for professionals working with emotionally handicapped/severely emotionally disturbed children.

SPEAKERS:
Dr. Lyndal Bullock, North Texas State University
Dr. Ellis Geston, University of South Florida
Dr. Ron Laneve, Mark Twain School
Dr. Nick Long, American University
Dr. William Morse, University of Michigan
Dr. William Rhodes, University of South Florida
Dr. Diana J. Wells, DOE, Tallahassee

DATE: February 18, 1984

SITE:
Morningstar School of Pinellas Park
4661 - 80th Ave. North
Pinellas Park, Florida

REGISTRATION FEES: Registration will be limited to 225 participants. Please, only professionals working with EH/SED students may register for this conference. Registration materials will be forthcoming in January, 1984. No fees will be assessed. For additional information please call:

Maureen Gale
SED Network
4960 - 78th Avenue North
Pinellas Park, Florida 33565
(813) 541-4449

SPONSORS:
FDLRS Gulfcoast Center
Hillsborough County Schools
Juvenile Welfare Board
Pinellas County Schools
SED Network

Special appreciation to Morningstar School of Pinellas Park for the use of their facility and the University of South Florida for coordinating CEU credits.

Future Planning

SED Network staff are now planning presentations, public relations activities and information dissemination activities for fiscal year 1984-85 beginning July 1, 1984. Planning presently involves two activities. The first is a week of pre-school sessions and workshops for personnel serving SED students in Pasco and Pinellas counties. Topics include (1) affective counseling skills, (2) relaxation techniques, (3) aggression control techniques (ACT), and (4) awareness of cultural differences. This week of sessions is voluntary inservice training to be held August 13-17, 1984. A $30.00 per day stipend will be provided for participants.

The second activity that SED Network staff are now preparing for includes eight (8) presentations to be presented at three conventions. The presentations have not been formally accepted but each of them are submitted for presentation. The conventions and session titles are listed below.

1. July 11, 1984
   Florida Council for Community Mental Health, Inc. - Tampa, Fl.
   Case Management

2. August 21, 1984
   FDLRS-Gulfcoast Educational Conference - Clearwater, Fl.

   a. Vocational Planning for Severely Emotionally Disturbed Students

   b. Merging Educational and Treatment Strategies for the SED Student

3. October 11-13, 1984
   The National Adolescent Conference on Behavior Disorders - Pensacola, Fl.
   Community Based Classroom Program

4. October 18-20, 1984
   Florida Federation Council for Exceptional Children
   1984 State Conference - Tampa, Fl.

   a. Community Based Classroom Program
   b. Vocational Education Options and Affective/Educational Goals and Objectives, and
   c. Use of Video Tape Activities with SED Students

5. April 15-19, 1985
   Council for Exceptional Children
   63rd Annual Convention
   Anaheim, California

   a. Community Based Classroom Program
   b. Linkage of Services for SED - Education, Mental Health, Residential Treatment, and Juvenile Justice System
   c. Use of Video Tape Activities with SED Students, and
   d. Case Management for SED

Notification for these sessions should be received by August, 1984. Specific details fo each session will then be planned.

Summary

SED Network staff have participated in a wide variety of inservice training and information dissemination activities. These activities include (1) presentations at conferences, (2) inservice workshops, (3) community awareness activities, (4) conference planning, and (5) public relations activities (i.e., newspaper and newsletter articles). In addition, the SED Network was one of five sponsors of a regional conference.

Future plans include inservice training during the Fall, 1984 and presentations at conferences during the 1984-85 year.

PARENT SUPPORT GROUP

Summary Report

Prevalence figures published by the Office of Special Education and Rehabilitive Services (OSERS) indicate that approximately 0.5% of individuals between the ages of 3-21 would require special education services due to severe emotional problems. As more students are identified and certified as severely emotionally disturbed (SED) in the Pasco/Pinellas region, it becomes imperative to provide an educationally and therapeutically sound program for these students.

Three basic components have been identified for a successful program for SED students. These components were recommended by the Pinellas County Schools Department of Education for Exceptional Students Program for Emotionally Handicapped Students Task Force. As indicated in the Task Force Report (1979-80) the three components are:

1. description of priority goals and methods designed to bring about desired behavioral changes,

2. utilization of a wide variety of techniques for controlling inappropriate behavior and building coping skills, and

3. provision of support and intervention to create greater understanding of individual student needs.

A program such as this requires the cooperative efforts of education personnel, mental health professionals, students, and the family unit to assure that the needs of the SED population are met.

The SED Network has been charged with identifying service gaps for SED students and providing a complete array of support and intervention. To accomplish this goal SED Network staff under the guidance of the SED Network Advisory Committee have developed several activities. One of these activities emphasizes the importance of parent involvement and support as an integral part of the SED students' total program. SED Network staff, education personnel and mental health professionals have identified family involvement and support as a major priority in the Pasco/Pinellas region. Therefore, SED Network staff agreed that establishing a Parent Support Group at each of the SED Centers would improve the already existing services at these Centers. Planning of this activity occurred by involving both mental health and school based personnel and SED Network staff.

Data generated from two needs assessments indicated a strong need for support activities for parents of severely emotionally disturbed (SED) students in Pinellas County. Following the directives of improving the quality of existing services, the SED Network assisted in filling this service gap by providing funding for two Parent Support groups using staff development funds. The Parent Support groups were located at (1) Richard L. Sanders School and (2) Safety Harbor Exceptional Student Center. Both of these sites serve the severely emotionally disturbed population of students in Pinellas County.

Planning Process

The planning process for developing and implementing the Parent Support groups involved SED Network staff, SED Center principals, and Mental Health and School-based personnel. A brief summary of each planning meeting is listed below:

1. October 15, 1983 - A planning meeting was held with Maureen Gale, Training and Resource Liaison and Lee Sherry, Project Manager to outline the planning process and determine monies available for this activity.

2. October 17, 1983 - A planning meeting was held with the following people:

   Rick Nelson, Social Worker, Safety Harbor Exceptional Student Center
   Sue Blue, Psycnologist, Richard L. Sanders School
   Ray Koscho, Social Worker, Richard L. Sanders School
   Maureen Gale, Training and Resource Liaison, SED Network

   During this meeting it was decided to conduct two Parent Support Groups, one at Richard L. Sanders School and one at Safety Harbor Exceptional Student Center. The contract for this activity was outlined and tentative dates were scheduled.

3. November 8, 1983 - A planning meeting was held with Rick Nelson, Social Worker, Marilyn Jones, Psychologist, and Maureen Gale, Training and Resource Liaison to outline the Parent Support Group activity at Safety Harbor Exceptional Student Center. Support Group meeting dates were set and publicity discussed.

4. January 9, 1984 - A planning meeting was held by Rick Nelson, Social Worker and Marilyn Jones, Psycholcgist to design publicity for the Parent Support Group. Publicity flyer given to Maureen Gale, Training and Resource Liaison to be copied (see Appendix I).

5. January 23, 1984 - Parent Support Group began at Safety Harbor Exceptional Student Center. Co-facilitators are Rick Nelson, Social Worker and Marilyn Jones, Psychologist.

6. January 24, 1984 - Parent Support Group began at Richard L. Sanders School. Co-facilitators are Dr. Sue Blue, Psychologist and Ray Koscho, Social Worker.

Description of Service

Location

Two Parent Support Groups were implemented for parents of SED students in Pinellas County. These two groups were located at 1) Richard L. Sanders School and 2) Safety Harbor Exceptional Student Center.

Facilitators

Four school-based personnel co-facilitated two Parent Support Groups. At Richard L. Sanders School the co-facilitators were Dr. Susan Blue and Raymond Koscho. Raymond Koscho is a School Social Worker and Dr. Blue is a School Psychologist.

The co-facilitators of the Parent Support Group at Safety Harbor Exceptional Student Center were Rick Nelson, School Social Worker and Marilyn Jones, School Psychologist.

In addition, SED Network staff worked with the facilitators in an advisory capacity.

Publicity/Meeting Dates and Times

Publicizing the Parent Support Groups was implemented using three methods. They were (1) publicity flyers sent home to parents, (2) phone calls to parents, and (3) face-to-face communication with parents.

The meeting times for both support groups were 7:00 p.m.-8:30 p.m. The Richard L. Sanders Support Group met on Tuesday evenings, twice per month. The Safety Harbor Exceptional Student Center Parent Support Group met on Monday evenings, once per month.

Funding

Funding for both the Parent Support Groups was limited to the hourly wages of the facilitators. Facilitators were reimbursed according to the guidelines written in the Pinellas County School Board Staff Development Policy Manual. These wages were paid by the SED Network through the Staff Development budget line.

Goals and Objectives

The goal of the Parent Support Groups was to provide parents of SED students the opportunity to meet with professional SED Center staff and other parents of SED students. In addition, it was a goal of these groups to improve family functioning through increased parental awareness and effectiveness.

The following activities took place during the Parent Support Group meetings:

1. individual and group parent education,
2. individual and group counseling for parents,
3. facilitating of peer support within the group,
4. home visits as needed,
5. referrals to outside agencies as needed, and
6. evaluation of the Parent Support Groups.

Using the above activities as guidelines the facilitators outlined the following topics for discussion during the Parent Support Group meetings. The topics were:

1. community resources,
2. the school program,
3. crisis resolution,
4. contracting,
5. shaping behavior,
6. increasing self-esteem in students,
7. decreasing stress factors, and
8. additional topics (as indicated by the participants).

Evaluation

Facilitators completed a Parent Support Group Summary Form monthly for evaluation purposes. This form was adopted from the Montgomery County Intermediate Unit (1978) Learning and Adjustment Program (see Appendix II).

The facilitators of the Parent Support group each submitted five (5) Parent Support Group Summary Forms for evaluation/monitoring purposes. Facilitators were asked to describe and/or identify six items. They were (1) tone of group at start of session, (2) main theme of group, (3) description of group interaction, (4) description of issues discussed, (5) tone of group at conclusion of session, and (6) topics to be discussed during next group. In addition, facilitators were asked to submit additional comments if they so desired.

The content of these evaluation forms are summarized in Tables 1 and 2. Table 1 shows the evaluation information from Richard L. Sanders School and Table 2 shows the evaluation information from Safety Harbor Exceptional Student Center.

In addition, the parents and facilitators of the Safety Harbor Exceptional Student Center Parent Support Group developed and distributed a Parent Questionnaire. The purpose of the questionnaire was to gather information relative to parents attitudes toward the school, placement decisions, and after school activities. A summary of the responses is attached. See Appendix III.

TABLE 1

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ITEM	1/24/84	2/21/84	3/6/84	4/3/84	5/1/84
Tone of group at start of session	Wary, tentative, curious - exhibiting a "wait and see" posture.	Expectation of didactic session, some discomfort due to one participant being visibly upset.	Comfortable	Some uneasiness, new participants were present.	Confident and interacting.
Main theme of group	Exploration	Discussion of problems encountered with relatives who do not understand exceptionalities.	Identifying lifelines.	How to deal with acting out child in public.	Referral services available to parents, information seeking.
Description of group interaction.	Problem-solving and supportive.	Problem-solving, insightful and later supportive.	Supportive	Problem-solving.	Problem solving, supportive, informative.
Description of issues discussed.	Group cohesiveness, parenting problems, group continuance.	Use of extinction, maximizing teaching potential, avoiding embarrassing situations.	Making use of available resources and identifying resources.	Teasing between siblings, damage to property, tantrums before strangers.	After-school care and vocational rehabilitation.
Tone of group at conclusion of session.	Closeness and shared understanding.	Supportive, cohesive.	Sincere supportiveness between participants.	Acknowledgement of input of all participants - supportive.	Relaxed and supportive.
Topics to discuss during next group.	Continue topics brought up during discussion.	What will happen to my child when I'm no longer here.	Self-statements, cognitive controls.	Encouraging association with appropriate models.	End of school year, topics to discuss during the summer.
Additional comments.	Group went well especially for this first large attendance. More participation and willingness to share than expected.	None.	Both participants seemed to benefit from this smaller group. 1-1 contact was helpful.	Many questions raised, participants actively participating and raising issues for consideration in future groups.	
Number of Participants	13	7	2	4	5

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TABLE 2

ITEM	1/23/84	2/27/84	3/5/84	4/2/84	5/7/84
Tone of group at start of session	Friendly	Somewhat hostile, parents shared problems with the school system, and seemed to blame the school system for their children's problems.		Group members seemed anxious, possibly due to uncertainty of the nature and purpose of the group.	Disappointment at poor turn out. Parents that attended were committed to developing Parent Questionnaire.
Main theme of group	Assessment of Parent needs.	Parents feelings about their children being at the center.		Group members offered suggestions to improve parent support.	Development of Parent Questionnaire.
Description of group interaction.	Supportive of each other despite differences in their children.	Clarified the point system and problems at home and school.		Members supported each other while relating experiences. Began developing parent questionnaire	Good interaction between parent and leaders. Interest at meeting new principal.
Description of issues discussed.	Purpose and goals of group. Problems parents have at home and school. What it means to be "SED" and how it feels to be a parent of an SED child.	Discussed the point system and causes of student's problems. Discussed dealing with problems at home.		Discussed lack of parent support to the school and possible reasons for the lack of support. Parent Questionnaire development.	Possible reasons for poor turn-out and method for distributing parent questionnaire.
Tone of group at conclusion of session	Pleasant, friendly.	Much more relaxed. Seemed to understand the school better and supported their child's placement.		Cohesive and friendly.	Parents seemed to be pleased with the meeting. They valued the opportunity to act as a resource for school personnel.
Topics to discuss during next group.	Specific situations and what parents can do to intervene, include real situations, how they were handled and the outcome	Check on student's behavior specific solutions and interventions for student's problems.		Development of Parent Questionnaire.	Last meeting discussion involved topics for next year.
Additional comments.	Gave parents a chance to talk about how hard it is to raise a child with severe problems.	Parents seemed to overlook their possible responsibility for their student's problems.	Facilitators will try to publicize the group to more parents.	Seemed to make a good start at developing a core group of interested parents.	A disappointment to facilitators to have so few parents participate.
Number of Participants	3	2	0	5	2 Principal also attended.

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CONCLUSIONS

1. A need exists for programs serving severely emotionally disturbed students to offer parent support activities.

2. Parents that participated in school-based support activities felt that their involvement was appreciated.

3. Parents that participated in school-based support activities gained a greater understanding of their childrens' needs and the school strategies and techniques for working with SED students.

4. School personnel gained an understanding of parent needs as well as strategies for involving parents in school activities.

5. Communication was improved between parents and schools.

6. Parents that participated appreciated the school reaching out to include them in activities.

7. Parents stated that the Parent Support Group activity emphasized the concern that SED Centers had for parents and their children.

8. Parent Support Group facilitators require additional time to plan support group activities.

9. Parent Support Group facilitators needed additional time to actively solicit parents to participate in the support groups.

RECOMMENDATIONS

1. Parent Support Groups should be established at each location serving severely emotionally disturbed students.

2. Facilitation of Parent Support Groups should be the responsibility of the school psychologist and the school social worker (or other mental health professionals).

3. As soon as possible supervisors should rewrite specific support staff job descriptions to include Parent Support Group activities.

4. Parents should be notified of parent support activities when their child is initially placed in an SED program.

5. The Parent Support Group should be an ongoing strategy to facilitate school/home communication as well as problem solving activities.

6. Planning time for facilitators should be built into the parent support activity.

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Appendix I

PARENT SUPPORT GROUP !!

Sometimes parenting a child with special needs can be an overwhelming challenge. Parents may run out of ideas, become frustrated and reach for the panic button because ... parents are people too!

We feel that parents of Safety Harbor students have a great deal to offer each other. Perhaps you would enjoy sharing experiences and suggestions about parenting an exceptional child with other parents.

We hope, also, to provide useful, practical ideas and alternatives that you might find useful.

WHEN: Monday evening at 7:00 p.m.-8:30 p.m.
FIRST MEETING - January 23, 1984

WHERE: School Cafeteria
Safety Harbor Exceptional Student Center
675 Elm Street
Safety Harbor

Refreshments will be provided. There is no charge. Please call the School for more information - 726-4827. Session leaders are

Marilyn Jones - School Psychologist
Rick Nelson - School Social Worker

SEE YOU THERE!

Appendix II

PARENT SUPPORT GROUP SUMMARY FORM*

Group Leaders_____ Date_____

_____ Number of Participants ____

Please identify the following.

1. Tone of group at start of session:

2. Main theme of group:

3. Description of group interaction (i.e., problem solving, insighful, supportive hostile):

4. Description of issues discussed:

5. Tone of group at conclusion of session:

6. Topics to discuss during next group:

7. Additional Comments:

* Adapted from MCIU (1978)

Appendix III

PARENT QUESTIONNAIRE

Please check yes or no in column on right for questions 1 - 14.

		YES	NO
1.	Do you agree with the decision to place your child at Safety Harbor Exceptional Center?	26	4
2.	Would you like to be more involved with the school?	24	5
3.	Are you satisfied with the school's efforts with your child?	28	2
4.	Do you feel that the school works in the best interest of your child?	28	2
5.	Are you satisfied with the school's discipline policies?	24	6
6.	Would you rather your child be place in another school?	10	20
7.	Are you satisfied with the present administration?	25	4
8.	Is one of the reasons you do not attend school functions a lack of transportation?	5	25
9.	Does the teacher try to maintain contact with you on a regular basis?	27	3
10.	Would you like to speak with your child's teacher more often?	20	10
11.	Do you feel the teacher is fair in dealing with your child?	28	2
12.	Would you be willing to participate in evening functions at the school if we provided child care at Safety Harbor Exceptional Center?	16	14
13.	Would you be willing to participate in afternoon functions at the school if we provided child care at Safety Harbor Exceptional Center?	17	15
14.	Do you see your child returning to a regular classroom in the future?	28	8

15. The things I like best about the Center are: small classes - 4: teacher/staff - 11: counseling - 2; communication - 4; speech - 1

16. The things I like least about the Center are: lack of communication - 1; location - 7; school bus behavior - 2; discipline - too harsh - 2, too lenient - 1, corporal - 1; parking facilities - 1; lack of student activities-1

THE DEVELOPMENT OF AN INFORMATION & REFERRAL GUIDE

STATEMENT OF PURPOSE:

The Information & Referral Guide was developed for use by professionals in the areas of education, mental health, juvenile justice, medical services and other community service agencies.

This Guide initially resulted from a need identified by Pasco County School personnel. The SED Network staff worked in conjunction with Alternative Human Services (AHS) in the production of this Guide. The Information and Referral Guide to Services for Severely Emotionally Disturbed Children and Youth is a comprehensive document. Included within the Guide is information on available local services relevant to the SED child. Specific areas of resource are:

1) Counseling
2) Educational Programs
3) Health & Rehabilitative Services
4) Psychiatric/Psychological Services
5) Residential Facilities
6) Vocational Programs
7) Consumer Assistance
8) Medical Services
9) Abuse Information

PROJECT DESCRIPTION:

The SED Network staff has acted as facilitator to coordinate the development of the Information & Referral Guide. The production of the Guide represents multi-agency cooperation and sharing of resources among two school districts and Alternative Human Services.

This first edition of the Guide was developed to be used by local professionals. These professionals include mental health practioneers, educators, human services providers, doctors, clergy and other professionals who deal with severely emotionally disturbed children and their families.

Each entry in the Guide describes the program, lists referral criteria as well as telephone and address information. Unique to the Guide is a section devoted to Exceptional Education Programs in both the Pinellas and Pasco School Districts. Descriptions of handicapping conditions, program offerings and contact personnel are contained in the Guide. This type of concise, self-contained manual of special education services is the first of its type in the Pinellas/Pasco region.

The I & R Guide was distributed to 20 members of the SED Advisory Committee. In order to assess the effectiveness of the Guide a questionnaire was developed by the SED Staff. The questionnaire was used by the professionals to tally opinions, concerns and errors related to the Information and Referral Guide. The following is a summary of responses to each item on the Information & Referral Publication Review.

1. The title "Information and Referral Guide was chosen by a majority of those who responded to the questionnaire. Respondents felt that the word "Guide" was less threatening.

2. Although a majority of those surveyed believed the I & R Guide would be of interest to a parent or guardian of a SED child, informal feedback has prompted the development of a less comprehensive Guide for parents. It was felt that the I & R Guide would be too inclusive and thereby overwhelming to parents seeking guidance and introduction to a few service providers.

3. Those surveyed unanimously agreed that the programs listed in the Guide are of interest to professionals who may encounter the SED child or youth.

4. Those reviewing the I & R Guide suggested a total of eight additional programs to be included in the Guide. All of these programs were included in the revised edition.

5. Reviewers of the manual stated that there was no program included in the I & R Guide that should be deleted.

6. All but one respondent felt that the program descriptions were easy to understand. However, it was stated that the chapter on Educational Programs was too professional to be used in the Parent Guide.

7. It was the unanimous consensus of those surveyed that the program descriptions were adequate to describe services offered by each agency. Several suggestions were incorporated into the revised edition.

8. All typographical errors, inaccurate information and missing information (27 changes in all) have been included in the revised copy.

9. Respondents saw a variety of uses for the I & R Guide. These suggestions included but were not limited to:

    1) a guide to share with parents during conferences
    2) a quick personal reference guide
    3) useful for the Department of Education for Exceptional Students (DEES) screening team
    4) useful for school staffing and support teams
    5) an excellent resource for guidance counselors
    6) to be used as a placement resource for students exiting Eckerd Camps and other residential facilities
    7) excellent resource for hospital staff
    8) useful resource for directors of discipline in each school system

10. Those surveyed indicated that the I & R Guide would be an aide to parents and guardians of the SED child or youth. Usage of the Guide by parents consisted of:

    1) a quick concise "lifesaver" of community services
    2) a complete perspective of community services
    3) provide parents useful information that will inable them to contribute to the decision making process for their child's program

Overall, the general consensus on the usefulness of the I & R Guide was extremely positive. The I & R Guide will be distributed to professionals in Pinellas and Pasco County by the end of June, 1984. Included in the Guide is an evaluation form to be used by professionals to communicate any additional services applicable to the severely emotionally disturbed population. Suggestions for corrections, revisions or deletions can be recorded on the form. All evaluations are to be sent to the SED Network who will facilitate any revisions.

QUARTERLY REVIEW OF PROJECT ACCOMPLISHMENTS

Mary A. Ellzey, Ph.D., Evaluation Consultant, Evaluation Systems Design, Inc.

PURPOSE: The purpose of the quarterly status report is to describe the accomplishments of the Pinellas/Pasco Multiagency Network for Severely Emotionally Disturbed Students. Primary concern centers on documentation of whether the project is being implemented as planned and identification of conditions which constrain or facilitate project implementation. Detailed evaluation results for specific project components are reported in other documents. The review process is intended to result in observations and recommendations which are helpful in planning, management, and evaluation of the project.

PROCEDURE: Quarterly status reports of project accomplishments are the result of an onsite visit to the project. During the onsite visit, each professional staff member is interviewed and documentation and products are reviewed relative to the staff member's assigned responsibilities for project activities. The information obtained from the process is compared with the project plan and with more detailed action plans which are designed to structure the day to day activities aimed at accomplishment of project objectives and goals. When interim onsite visits occur similar activities are conducted with the staff and a brief, written update to the quarterly status report is provided. The information is cumulative in nature and the reader may wish to refer to subsequent quarterly reports and interim correspondence.

EVALUATION SYSTEMS DESIGN, INC.
Review of Project Accomplishments
March 21, 1984
Mary A. Ellzey, Ph.D., Evaluation Consultant

GOAL 1 - PROVISION OF A COMPLETE ARRAY OF EDUCATION, MENTAL HEALTH TREATMENT, AND RESIDENTIAL SERVICES

Objective 1 - verify interface with juvenile courts.

A detailed action plan has been developed for use in accomplishing the tasks associated with this objective. Maureen Gale has been assigned the day to day tasks. The tasks have been initiated and no significant delays or constrains in completion of the objective are anticipated, with the exception of computerization of the data. The data can be entered into the word processor providing for access and update until computer resources are available.

Objective 2 - expand community awareness of services for SED students and parents.

Tasks associated with this objective are ongoing. Copies of news articles, newsletter articles, and evaluations of professional presentations are maintained. Contact has been made with the school district's public relations representative and assistance is available, as needed. Development of a brochure and some audio-visual support for presentations are recognized as needs by project staff but may be of low priority.

Objective 3 - identify direct service gaps.

Use of needs assessment data to identify service gaps is an ongoing process. The Network participated in the use of such data for planning and initiating a new day treatment program in south Pinellas. The program began on January 24, 1984. Such planning and program development activities will continue to occur as the opportunities arise.

Objective 4 - expand the availability of adolescent treatment programs.

Network funds are utilized to provide a Mental Health Specialist I at Human Development Center of Pasco (HDC) for the period of January - June, 1984. HDC has committed to picking up this position after June 30. Funds are to be obtained via moving the day treatment program to a school site. This solution has required cooperative planning. Evaluation of the effectiveness of the Mental Health Specialist is being conducted by the HDC supervisor on a monthly basis, using a standard form. The information is reviewed by Lee Sherry prior to authorizing payment.

GOAL 2 - IMPROVEMENT OF EXISTING EDUCATION, MENTAL HEALTH TREATMENT, AND RESIDENTIAL SERVICES

Objective 1 - evaluate the ITEP.

Please refer to the discussion of the evaluation of the ITEP in the attached letter. A detailed action plan has been developed for piloting, evaluation and revision of the ITEP. Mike Tomalesky is coordinating the accomplishment of the day to day tasks. Tasks for this objective have essentially been reorganized. No significant delays or constraints in completion of the objective are anticipated.

Objective 2 - evaluate the use of developmental hierarchies, both affective and academic.

Tasks associated with this objective have not been initiated. The developmental hierarchies are currently being developed, as described in the 1983 goal. Once initial development is completed, plans for evaluation will be reviewed and revised, as needed. I observed the first meeting of the development groups in February.

Objective 3 - develop observation instruments to collect behavioral data as defined by the ITEP.

Plans are to initiate this activity on about May 1, 1984. It is thought that the developmental hierarchies will be in a sufficient state to support this next step in the development process, by that time. This delay in initiation of the tasks should not have a significant impact on the accomplishment of the objective.

Objective 4 - expand the availability of vocational education programs to SED students.

Carol Makin has been assigned the responsibility of coordinating the day to day tasks associated with this objective. In addition, a doctoral student, Bee Crews, has been obtained from the University of Florida, via TEC hours, to assist with the effort. Tasks have been initiated as specified in the detailed action plan developed for this objective. Face to face contacts with key administrators in ESE vocational education, vocational rehabilitation, and vocational/technical have been accomplished. Group meetings are being planned to collect written and verbal information from direct providers.

Objective 5 - expand residential treatment placement options.

As currently written, this objective should be deleted from the project scope. The Juvenile Welfare Board has put this expansion effort on hold, negating the possibility of Network staff being able to provide assistance.

Objective 6 - expand alternatives to residential treatment placement options.

The South Pinellas Adolescent Day Treatment Program has been established. Network staff should clarify their program development role with the program, as described in the project application. Sub-objectives and activities should be carried out or deleted, based upon such clarification.

Objective 7 - establish policies and procedures for a school-based, alternative alternative to suspension program for SED Centers in Pinellas County.

Policies and procedures for the Community Based program have been developed. Funding for the program was sought and obtained from the Juvenile Welfare Board. The program has begun and is to be evaluated by Mental Health of South. Network staff have discussed the need for evaluative data with program staff. SED Network staff will continue to consult with the program, as needed. To date, utilization of the program is an issue. Not as many students have been served as were projected. The program is funded through July, 1984. In June, Network staff are scheduled to begin development of a technical assistance report on the program.

Objective 8 - improve theraputic approaches and techniques used in school-based SED programs.

This has become known as the "video-tape" project. Day to day tasks are assigned to Maureen Gale. A research study was developed and is currently underway. Consultation for the study has been obtained from the University of Florida. Data collection should be completed within approximately 2 weeks.

Objective 9 - improve hospital intake procedures for students.

Two approaches are being taken to accomplish this objective. The first approach is that Lee Sherry is making personal contacts with hospital personnel. The purpose of the contacts is to establish working relationships and to collect basic information about hospital services and procedures. Hospital representatives are also being invited to present information to the Network Advisory Committee. Two such presentations have been completed to date. A strategy for obtaining one representative of hospital programs to the Advisory Committee is being pursued.

The second strategy for improvement is through the work of the case management committee. Hospitals will be considered along with all other major service providers.

Objective 10 - improve teacher/mental health technician effectiveness through staff development designed to enhance the therapeutic milieu in SED classes.

Tasks associated with this objective have become known as "teacher support groups." Day to day tasks are assigned to Maureen Gale. Several activities have occurred, some more formal and directly related to Network intervention than others. Activities have included meetings with a principal and support staff, demonstration of affective group techniques, provision of relaxation and recreational therapy, and training on the "teacher as therapist."

Consideration should be given to addressing the needs of teachers through the development of policies and procedures for ongoing implementation in local school districts. As we discussed, perhaps the approach would be to think about what kind of ongoing system can be established so that the needs of new and continuing teachers are assessed and met. For example, policies, procedures and forms needed by a principal for making sure that support needs are identified and met could be developed and tested by the Network. This type of systems approach to teacher support appears to me to have much more potential than addressing the needs of a small number of teachers, in one site, for a limited period of time.

Objective 11 - expand adolescent day treatment options.

This objective was essentially accomplished with the implementation of the South County Adolescent Day Treatment Program.

GOAL 3 - CONTINUOUS MULTIAGENCY PLANNING, IMPLEMENTATION, AND EVALUATION OF SED PROGRAMS AND SERVICES

Objective 1 - improve effectiveness of communication and coordination

Tasks associated with this objective are ongoing. Results are observed in monthly Advisory Committee meetings and the many task groups which are operating.

Objective 2 - verify the adequacy of the definition and placement criteria for SED students.

Tasks associated with this objective have not been initiated. Much discussion has occurred however, regarding the need for and the approach to accomplishment of the objective. It appears that the first few planned activities which include collection of data which describe the SED population as it exists, based on current definition and criteria are worthy of pursuit and should be scheduled as soon as is feasible.

Objective 3 - maintain the Advisory Committee.

Tasks are ongoing. The committee appears to be working well based on my observations.

Objective 4 - identify, synthesize and expand on multiagency information

Tasks are ongoing. Specific tasks scheduled for completion through March have in fact been completed.

Objective 5 - identify present uses of advanced technology for use in development of a computerized system.

Planning for the tasks associated with this objective has begun. Mike Tomalesky will coordinate day to day tasks. I will assist in the development of an action plan and survey instruments.

Objective 6, 7, 8, and 9 - to define and refine the case management system.

Mike Tomalesky is assigned the day to day tasks associated with the objective. A task group is working on the accomplishment of required tasks. A survey of major provider agencies is being planned to determine the status of case management within each of the agencies. Minutes and products of the task group are better reflections of the intent and accomplishments than the vague language found in these objectives. At some future date a brief written description of how these objectives have been refined may be helpful.

GOAL 4 - DIFFUSION OF EXEMPLARY POLICIES AND PROCEDURES

Objective 1 - evaluate accomplishment of long and short range goals.

Staff meeting minutes, evaluation consortium agenda and minutes, and written information produced by the contracted evaluator are available as evidence for accomplishments to date for this objective.

Objective 2 - document communication strategies.

Tasks are ongoing and appear to be on target.

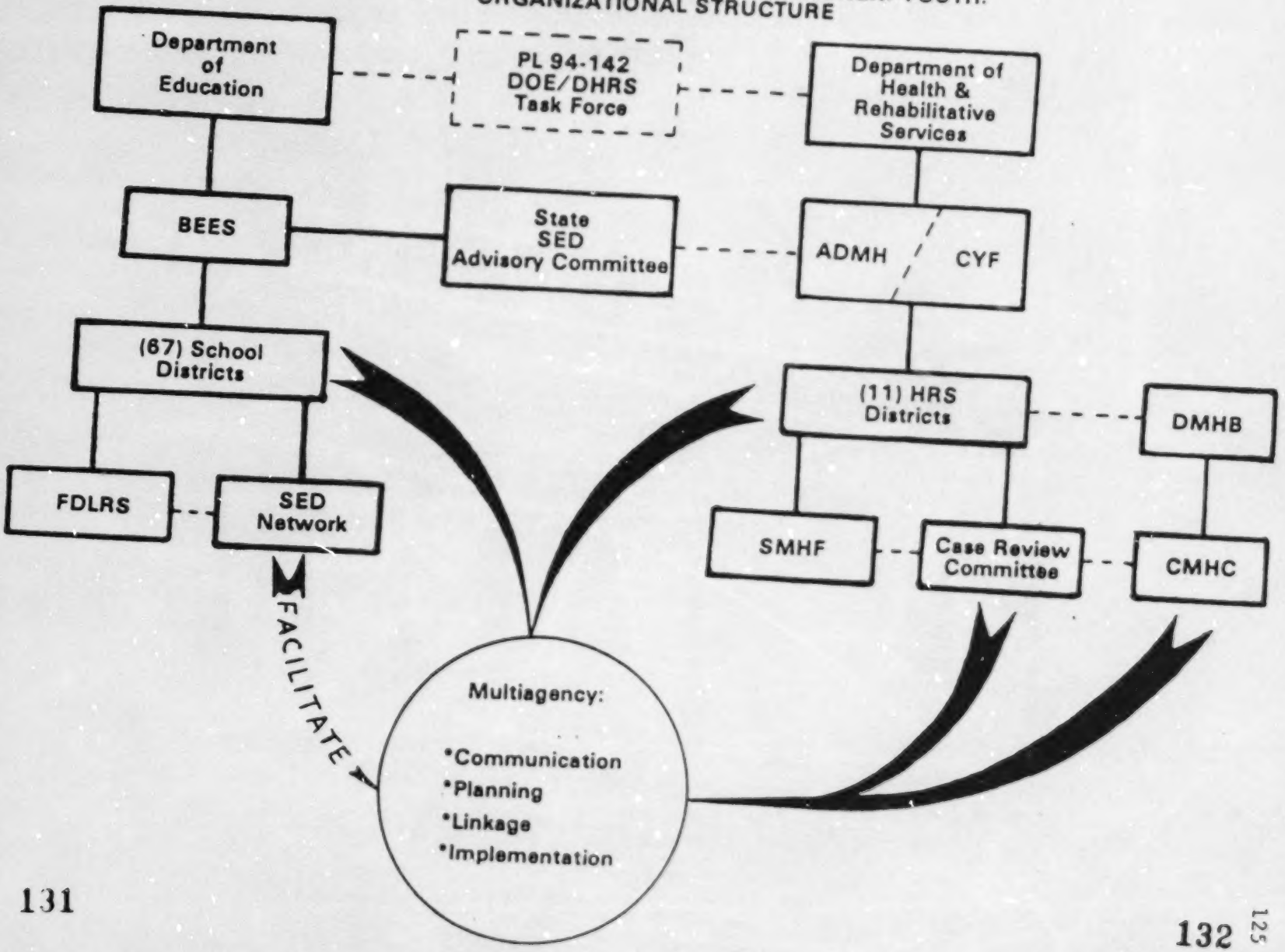
Objective 3 - develop and disseminate reports.

Ample documentation and reports of Network activity are in evidence.

SUMMARY

Based upon this review, it appears that the project is being implemented as planned. Project activities are generally being initiated and completed on time. Substantial evidence is available to document accomplishments during the first quarter of this funding year.

The project plan is well developed and should continue to be the foundation for all project activities. Documentation of constraints and facilitating conditions should continue to explain why accomplishments occur in varying degrees and at varying speeds. Where the initial ideas described in the project plan have become better refined through time and experience, brief rewrites of the objectives and sub-objectives may be beneficial.

The project is very complex and ambitious. The Network staff and all community participants are commended for the amount of time, thought, and commitment which are being displayed. Continued efforts of the same quantity and quality should ensure improved programs and services for severely emotionally disturbed students.

FLORIDA'S MULTIAGENCY NETWORK FOR SEVERELY EMOTIONALLY DISTURBED CHILDREN/YOUTH: ORGANIZATIONAL STRUCTURE